

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print) <b>BABY PAUL BOY BRIAN ALLEN</b>			2a. DATE OF DEATH Month <b>4</b> Day <b>9</b> Year <b>68</b>			2b. HOUR <b>12:35</b> PM			
3. SEX <b>MALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH <b>4-9-68</b>		6. AGE (In years lost birthday) YRS. MONTHS DAYS		IF UNDER 1 YEAR IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (State or foreign country) <b>CUMBERLAND, MD</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>ALLEGANY</b> Md.			
10. CITY OR TOWN OF DEATH <b>CUMBLAND</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>MEMORIAL HOSPITAL</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MD.</b>		13b. COUNTY <b>ALLEGANY</b>		13c. CITY OR TOWN <b>FROSTBURG</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <b>88 W. MAIN ST.</b>	
14. FATHER'S NAME First Middle Last <b>FRANCIS J ALLEN</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>SANDRA A DAVIS</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown)		(If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT <b>MEMORIAL HOSPITAL</b> Address <b>CUMBERLAND, MD.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>cystic lung disease</b> <b>748.4</b> DUE TO, OR AS A CONSEQUENCE OF: (b) <b>intracranial hemorrhage</b> DUE TO, OR AS A CONSEQUENCE OF: (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b> <b>1 day</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>1590</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>as above</b>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <b>4-8-</b> , 19 <b>68</b> , to <b>4-9-</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>4-9-</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>L. Mines</b>				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>4-10-68</b>			
22d. PHYSICIAN'S NAME (Type) <b>DR. MIKIO KATO</b>				22e. ADDRESS <b>LA VALE, MD.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE <b>4-10-68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>FBG. MEMORIAL PARK</b>		23d. LOCATION (City or Town) (County) (State) <b>FROSTBURG, MD.</b>			
24. FUNERAL DIRECTOR <b>J. R. DURST, FROSTBURG, MD. 21532</b>				25a. REC'D BY REGISTRAR DATE <b>APR 15 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

BABY BOY  
 ALLEN  
 10-10-10

WHITE  
 1-2-10  
 ALLEGANY

CUMBERLAND, MD.  
 U.S.A.  
 CUMBERLAND  
 MEMORIAL HOSPITAL  
 NO. 1 ALLEGANY  
 30 W. MAIN ST.

FRANCIS J  
 ALLEN  
 ZAHARA  
 CUMBERLAND, MD.  
 MEMORIAL HOSPITAL

(Faint, mostly illegible text in the middle section of the document)

DR. HIND KATO  
 LA VILLE, MD.  
 (Faint text at the bottom of the document)

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VR A15 (4)  
30M REV. 1/68

04958  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) <b>IRA</b>		First <b>IRA</b>		Middle <b>Kenneth</b>		Last <b>ARBOGAST</b>		2a. DATE OF DEATH Month <b>APRIL</b> Day <b>21</b> Year <b>1968</b>			2b. HOUR <b>8:05p</b> M		
3. SEX <b>MALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH <b>APRIL 26, 1892</b>			6. AGE (In years last birthday) <b>75</b> YRS.		IF UNDER 1 YEAR MONTHS <b>7</b> DAYS <b>15</b>		IF UNDER 24 HRS. HOURS <b>8</b> MIN <b>05</b>		
7a. BIRTHPLACE (State or foreign country) <b>W. VIRGINIA</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>ALLEGANY</b> Md.							
10. CITY OR TOWN OF DEATH <b>CUMBERLAND</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>MEMORIAL HOSPITAL</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Crane Operator</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Chemical Co.</b>							
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>W. Va.</b>		13b. COUNTY <b>ALLEGANY</b>		13c. CITY OR TOWN <b>Pay</b>		13d. INSIDE CITY LIMITS? <b>YES</b> <input type="checkbox"/> <b>NO</b> <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <b>Bedford Rd.</b>					
14. FATHER'S NAME <b>LEE</b>		First <b>LEE</b>		Middle <b>ARBOGAST</b>		Last <b>ARBOGAST</b>		15. MOTHER'S MAIDEN NAME <b>RACHEL</b>		First <b>RACHEL</b>		Middle <b>SIMMONS</b>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <b>No</b>		(If yes give war or dates of service)		16b. SOCIAL SECURITY NO. <b>217-01-1536</b>		17. INFORMANT <b>Mrs. Pearl Mitchell</b>		Address <b>Rt. #3 Bedford Rd. Cumb. Md.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: <b>4369</b> IMMEDIATE CAUSE (a) <b>C.V.A.</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Stroke</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>arteriosclerosis</b>											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>331x</b>													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? <b>YES</b> <input type="checkbox"/> <b>NO</b> <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. <b>19</b> Month <b>4</b> Day <b>21</b> Year <b>1968</b> P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)									
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. <b>Bedford Rd.</b> City or Town <b>Cumberland</b> County <b>Allegany</b> State <b>Md.</b>									
22a. I certify that (I) (this hospital) attended the deceased from <b>June 1968</b> to <b>April 21, 1968</b> that (I) (we) last saw the deceased alive on <b>April 19, 1968</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <b>DR. B. SCHINDLER</b>		DEGREE <b>M.D.</b>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>4/22/68</b>							
22d. PHYSICIAN'S NAME (Type) <b>DR. B. SCHINDLER</b>		22e. ADDRESS <b>CUMBERLAND, MD.</b>											
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>April 24, 1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Glen Haven Memorial Park</b>		23d. LOCATION (City or Town) (County) (State) <b>Glen Burnie Anne Arundel Md.</b>							
24. FUNERAL DIRECTOR <b>H. Lee Silcox</b>		ADDRESS <b>404 Decatur St. Cumb. Md.</b>		25a. REC'D BY REGISTRAR <b>APR 24 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>							



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MEDICAL CERTIFICATION

1. DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH Month Day Year			2b. HOUR	
JAMES		R	BAKER	4			30	68	1:00PM
3. SEX male		4. RACE WHITE		5. DATE OF BIRTH 2-16-97		6. AGE (In years last birthday) 68 71YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) VIRGINIA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH ALLEGANY Md.			
10. CITY OR TOWN OF DEATH CUMBERLAND		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) MEMORIAL HOSPITAL		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Allegany		13c. CITY OR TOWN Cumberland		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 215 Park Street	
14. FATHER'S NAME UNKNOWN		15. MOTHER'S MAIDEN NAME UNKNOWN							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown NO		16b. SOCIAL SECURITY NO. 220 10 7077		17. INFORMANT MEMORIAL HOSPITAL Address CUMBERLAND, MD.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Congestive heart failure with hypertension</i> 4109 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>Senile degeneration of heart muscle</i> DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 days	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4201									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from April 25, 1968, to April 30, 1968, that (I) (we) last saw the deceased alive on April 30, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>B. Schindler</i>		22c. DATE SIGNED 5/4/68		22d. PHYSICIAN'S NAME (Type) DR. B. SCHINDLER					
22e. ADDRESS CUMBERLAND, MD.									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 5/2/68		23c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park		23d. LOCATION (City or Town) (County) (State) Cumberland Md.			
24. FUNERAL DIRECTOR Byron Knight		25a. REC'D BY REGISTRAR MAY 3 1968		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>					

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<div style="display: flex; justify-content: space-between;"> <span>04961</span> <span>MARYLAND STATE DEPARTMENT OF HEALTH</span> <span>04962 PM</span> </div> <div style="text-align: center;">             DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  <b>CERTIFICATE OF DEATH</b> </div>																	
1. DECEASED-NAME (Type or print)			First <b>MARY</b>			Middle <b>F.</b>			Last <b>BARNES</b>			2a. DATE OF DEATH Month <b>APRIL</b> Day <b>27</b> Year <b>1968</b>			2b. HOUR <b>8:20</b> PM		
3. SEX <b>FEMALE</b>			4. RACE <b>WHITE</b>			5. DATE OF BIRTH <b>3-13-80</b>			6. AGE (In years last birthday) <b>88</b> YRS.			IF UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b>			IF UNDER 24 HRS. HOURS <b>0</b> MIN <b>0</b>		
7a. BIRTHPLACE (State or foreign country) <b>W. VA.</b>			7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <b>ALLEGANY</b> Md.								
10. CITY OR TOWN OF DEATH <b>CUMBERLAND</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>MEMORIAL HOSPITAL</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>HWEE.</b>			12b. KIND OF BUSINESS OR INDUSTRY								
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>W. VA.</b>			13b. COUNTY <b>MINERAL</b>			13c. CITY OR TOWN <b>RIDGELEY</b>			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER <b>41 SECOND AVE.</b>					
14. FATHER'S NAME First <b>ISAAC</b>			Middle <b>LEWIS</b>			Last <b>MARY</b>			15. MOTHER'S MAIDEN NAME First <b>MARY</b>			Middle <b>M.</b>			Last <b>BROWN</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) <b>NO</b>			16b. SOCIAL SECURITY NO. <b>236 58 0890</b>			17. INFORMANT Address <b>MEMORIAL HOSPITAL, CUMBERLAND, MD.</b>											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis</b> <b>433.9</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Generalized Arteriosclerosis</b> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b>																	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>332x</b>																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)											
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State <b>37/62 Cumberland Md</b>											
22a. I certify that (I) (this hospital) attended the deceased from <b>3/7/68</b> , 19 <b>19</b> , to <b>4/27/68</b> , 19 <b>19</b> , that (I) (we) last saw the deceased alive on <b>4/27/68</b> , 19 <b>19</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																	
22b. SIGNATURE <b>R.J. WILLIAMS</b>			22c. DATE SIGNED <b>4/28/68</b>			22d. PHYSICIAN'S NAME (Type) <b>R.J. WILLIAMS</b>			22e. ADDRESS <b>CUMBERLAND, MD.</b>			22f. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>			23b. DATE <b>4/30/68</b>			23c. NAME OF CEMETERY OR CREMATORY <b>Primitive Baptist Church</b>			23d. LOCATION (City or Town) (County) (State) <b>Three Chukles Wagon</b>								
24. FUNERAL DIRECTOR <b>Byron Light</b>			ADDRESS <b>Cumberland Md</b>			25a. MAY 3 1968			25b. REGISTERAR'S SIGNATURE <b>John Judge</b>								

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NAME: [illegible] SEX: [illegible] AGE: [illegible]

DATE: [illegible] TIME: [illegible]

W.A.V. [illegible] [illegible]

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

04963

1. DECEASED NAME (Type or print) First <b>Ellen</b> Middle <b>Lee</b> Last <b>Beeman</b>			20. DATE OF DEATH Month <b>4</b> Day <b>18</b> Year <b>1968</b>		26. HOUR M
3. SEX <b>Female</b>	4. RACE <b>White</b>	5. DATE OF BIRTH <b>1/3/1902</b>		6. AGE (In years last birthday) <b>66</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <b>Allegany</b> Md.		
10. CITY OR TOWN OF DEATH <b>Frostburg</b>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Miners Hospital</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life even if retired.) <b>House Wife</b>		12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md</b>	13b. COUNTY <b>Allegany</b>	13c. CITY OR TOWN <b>Lonaconing</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER <b>Roosevelt Avenue</b>	
14. FATHER'S NAME First <b>Abraham</b> Middle <b>Thompson</b> Last <b>Kerr</b>		15. MOTHER'S MAIDEN NAME First <b>Margaret</b> Middle <b>Kerr</b> Last <b>Kerr</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <b>no</b> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT <b>Hugh Beeman</b> Address <b>Lonaconing, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Ischemia</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Coronary Artery Disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Generalized Atherosclerosis</b> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>Acute Cellulitis left leg - Severe Rheumatoid Arthritis</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>12 hours</b> <b>years</b> <b>years</b>
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <b>1962 to 4-18-1968</b> , that (I) (we) last saw the deceased alive on <b>4-18-1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>L.R. Miles, Jr.</b>		DEGREE <b>M.D.</b>	ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>
22d. PHYSICIAN'S NAME (Type) <b>L.R. MILES, JR., M.D.</b>		22c. DATE SIGNED <b>4-19-68</b>			
22e. ADDRESS <b>Lonaconing, Md 21539</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>4/21/68</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Old Coney Cemetery</b>	23d. LOCATION (City or Town) <b>Lonaconing</b>	(County) <b>A.</b>	(State) <b>Md</b>
24. FUNERAL DIRECTOR <b>George Eichhorn</b>		ADDRESS <b>Lonaconing, Md.</b>		25a. REC'D BY REGISTRAR <b>Mar 22 1968</b>	25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>



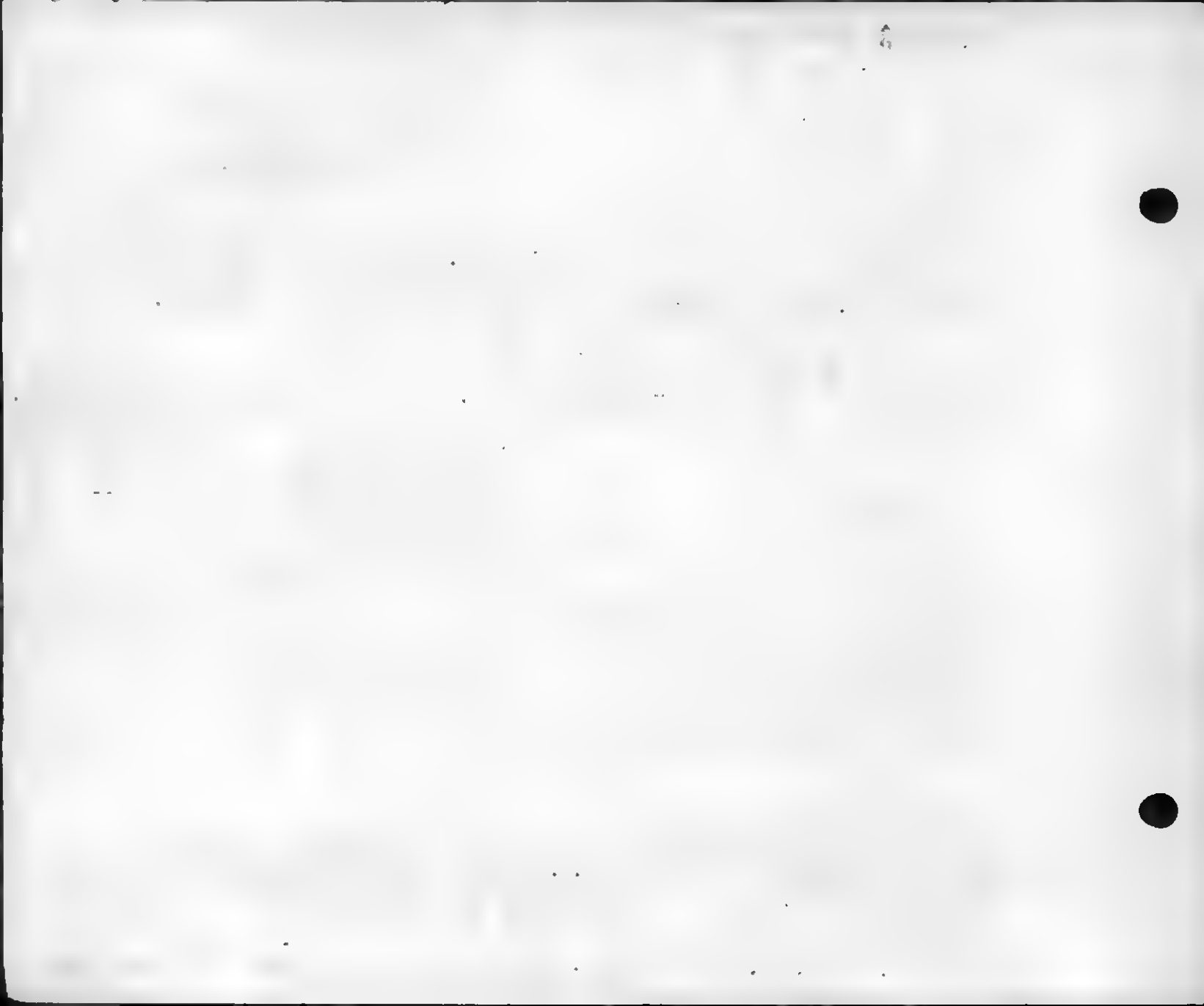
Name		Age		Sex		Race		Address		Occupation	
John Doe		35		Male		White		123 Main St		Teacher	
Jane Smith		28		Female		White		456 Oak Ave		Nurse	
Robert Johnson		42		Male		Black		789 Elm St		Farmer	
Mary White		31		Female		White		101 Pine St		Homemaker	
David Brown		25		Male		White		202 Cedar St		Student	
Susan Green		38		Female		White		303 Birch St		Librarian	
Michael Black		40		Male		Black		404 Maple St		Engineer	
Jennifer Lee		29		Female		White		505 Walnut St		Social Worker	
Christopher Davis		33		Male		White		606 Cherry St		Police Officer	
Amanda Wilson		27		Female		White		707 Peach St		Retail Sales	
Daniel Taylor		36		Male		Black		808 Apple St		Construction Worker	
Nicole Anderson		30		Female		White		909 Orange St		Marketing	
Kevin Thomas		41		Male		White		1010 Grape St		Accountant	
Stephanie Garcia		26		Female		Hispanic		1111 Lemon St		Graphic Designer	
Brandon Martinez		34		Male		Hispanic		1212 Lime St		IT Support	
Rachel Hernandez		29		Female		Hispanic		1313 Lemon St		Event Planning	
Justin Lopez		37		Male		Hispanic		1414 Orange St		Sales Representative	
Ashley Kim		28		Female		Korean		1515 Peach St		Translator	
Nathan Wright		43		Male		White		1616 Apple St		Retired	
Samantha Hill		32		Female		White		1717 Grape St		Public Health	
Ethan Scott		24		Male		White		1818 Walnut St		Software Developer	
Victoria Adams		35		Female		White		1919 Cherry St		Journalist	
Caleb Baker		39		Male		White		2020 Peach St		Business Owner	
Megan Evans		27		Female		White		2121 Apple St		Research Assistant	
Dylan Foster		31		Male		White		2222 Grape St		Project Manager	
Alexis Green		29		Female		White		2323 Walnut St		Human Resources	
Noah Hall		40		Male		White		2424 Cherry St		Operations Manager	
Sophia King		26		Female		White		2525 Peach St		Product Designer	
Liam Lee		33		Male		Korean		2626 Apple St		Data Analyst	
Olivia Miller		30		Female		White		2727 Grape St		UX Designer	
Carter Wilson		38		Male		White		2828 Walnut St		Systems Administrator	
Isabella Brown		25		Female		White		2929 Cherry St		Quality Assurance	
Mason Davis		42		Male		White		3030 Peach St		Finance Analyst	
Aria Evans		28		Female		White		3131 Apple St		Marketing Coordinator	
Logan Foster		36		Male		White		3232 Grape St		Sales Manager	
Zoe Green		27		Female		White		3333 Walnut St		Customer Support	
Julian Hall		41		Male		White		3434 Cherry St		Operations Director	
Ava King		29		Female		White		3535 Peach St		Product Manager	
Elijah Lee		34		Male		Korean		3636 Apple St		Software Engineer	
Mia Miller		26		Female		White		3737 Grape St		UX Researcher	
Caleb Wilson		39		Male		White		3838 Walnut St		Systems Engineer	
Isabella Brown		25		Female		White		3939 Cherry St		Quality Engineer	
Mason Davis		42		Male		White		4040 Peach St		Finance Director	
Aria Evans		28		Female		White		4141 Apple St		Marketing Director	
Logan Foster		36		Male		White		4242 Grape St		Sales Director	
Zoe Green		27		Female		White		4343 Walnut St		Customer Success	
Julian Hall		41		Male		White		4444 Cherry St		Operations Director	
Ava King		29		Female		White		4545 Peach St		Product Director	
Elijah Lee		34		Male		Korean		4646 Apple St		Software Engineer	
Mia Miller		26		Female		White		4747 Grape St		UX Researcher	
Caleb Wilson		39		Male		White		4848 Walnut St		Systems Engineer	
Isabella Brown		25		Female		White		4949 Cherry St		Quality Engineer	
Mason Davis		42		Male		White		5050 Peach St		Finance Director	

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/> April 13 1968		2b. HOUR 2 A.M.	
Donald Byron Bennett									
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		2c. DATE PRONOUNCED DEAD Month Day Year		2d. HOUR	
Male	White	July 31, 1904	63 YRS.			April 16, 1968		11 A.M.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Pennsylvania		U.S.A.				Allegany Md.			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY	
Cumberland			228 Harrison St.			Automobile Mechanic		Self Employed	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INDEED CITY OR TOWN?		13e. STREET AND NUMBER
Md.			Allegany		Cumberland		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		228 Harrison St.
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
George M Bennett			Amanda Wilson						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS				
No			220-164056		Homer C. Bennett, RFD2, Box 164A, Everett, Pa.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) _____ DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH STATE
CORONARY OCCLUSION									STATE
CORONARY SCLEROSIS									---
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?		
							YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
CAUSE OF DEATH		19							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE: <u>Benedict Skitarelic</u>			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED			
EXAMINER'S NAME (Type)			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			April 16, 1968			
BENEDICT SKITARELIC, M.D.			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			ADDRESS (Street, city, town, or county) Cumberland, Maryland			
23a. BURIAL, CREMATION REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		4/18/1968		Artemas Bennett Cemetery		Artemas Bedford Penna			
24. FUNERAL DIRECTOR			ADDRESS			25a. REC'D BY REG. STRAR		25b. REG. STRAR'S SIGNATURE	
John J. Hafer, Jr.			230 Balto Ave. Cumberland Md.			DATE APR 22 1968		Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

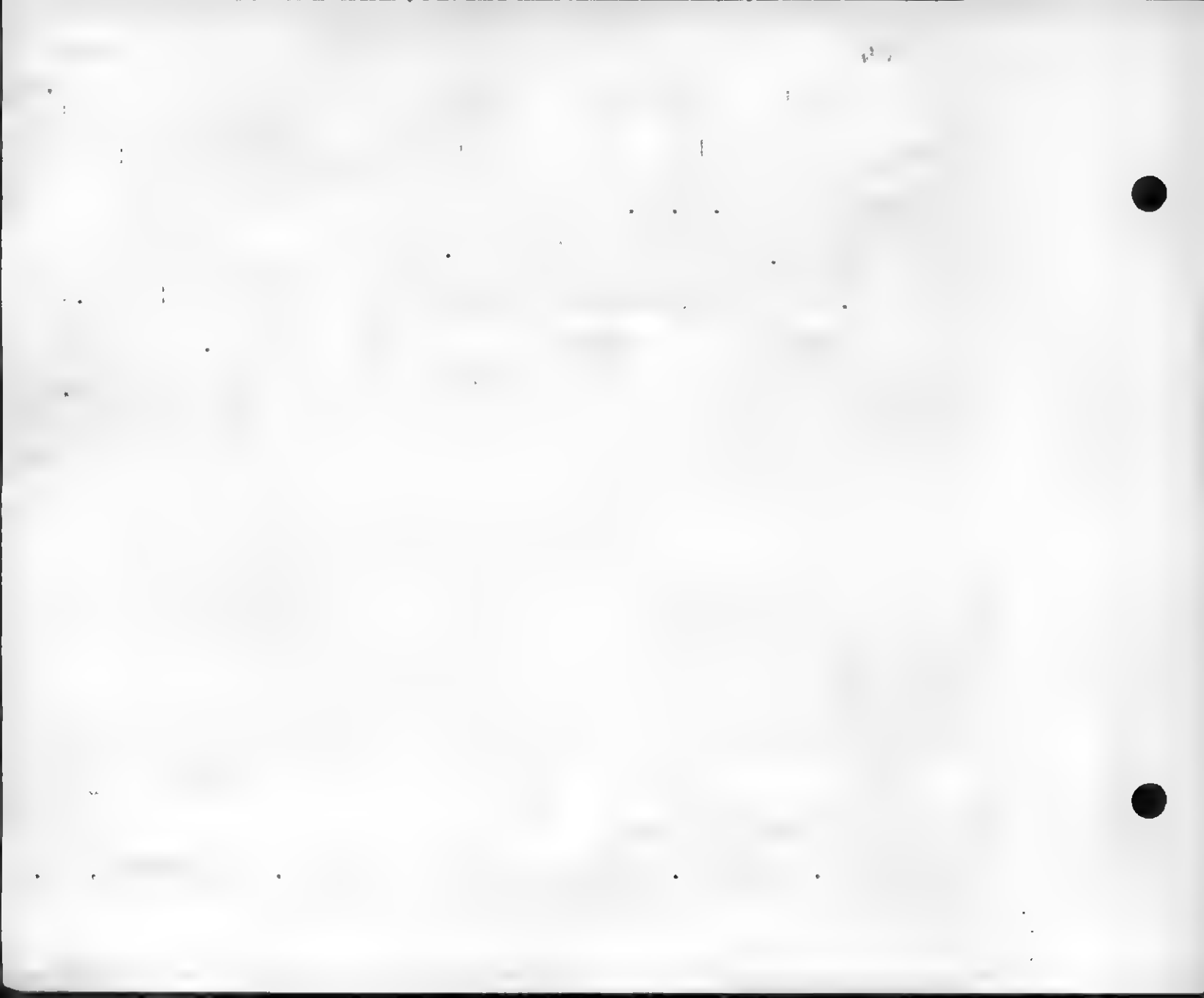
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
**CERTIFICATE OF DEATH**

1. DECEASED NAME (Type or print) <b>CYNTHIA LOUISE BLANK</b>			2a. DATE OF DEATH Month <b>4</b> Day <b>5</b> Year <b>68</b>		2b. HOUR <b>11:55</b>
3. SEX <b>FEMALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH <b>10-17-67</b>	
7a. BIRTHPLACE (State or foreign country) <b>CUMBERLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. COUNTY OF DEATH <b>ALLEGANY</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
10. CITY OR TOWN OF DEATH <b>CUMBERLAND, MD.</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>MEMORIAL HOSP.</b>		12c. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE <b>MD.</b>		13b. COUNTY <b>ALLEGANY</b>		13c. CITY OR TOWN <b>CUMBERLAND</b>	
13d. INSIDE CITY LIMITS? <b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/>		13e. STREET AND NUMBER <b>342 RESERVOIR AVE.,</b>			
14. FATHER'S NAME First Middle Last <b>RICHARD BLANK BLANK</b>			15. MOTHER'S MARIEN NAME First Middle Last <b>MARY L. RICE</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or unknown <b>NO</b> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT Address <b>MEMORIAL HOSPITAL - CUMBERLAND, MD.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia</b> <b>759.3</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Mongolism</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Congenital Heart Disease</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>325.4</b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? <b>YES</b> <input type="checkbox"/> <b>NO</b> <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or RFD No City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Robert D. Brodell</b>				22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (Type) <b>DR. ROBERT D. BRODELL</b>				22e. ADDRESS <b>500 GREENE ST., CUMBERLAND, MD.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <b>Apr. 7, 1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Sunset Memorial Park</b>	
23d. LOCATION (City or Town) (County) (State) <b>Cumberland, Allegany, Md.</b>					
24. FUNERAL DIRECTOR <b>James F. Scarpelli, Cumberland, Md.</b>				25a. REC'D BY REGISTRAR DATE <b>APR 9 - 1968</b>	
				25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

MEDICAL CERTIFICATION





**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**  
**CERTIFICATE OF DEATH**

04965			1		
1. DECEASED NAME (Type or print) First Middle Last <b>EZEKIEL OLIE BOBO</b>			2a. DATE OF DEATH Month Day Year <b>APR 1 10 1968</b>		2b. HOUR <b>8:35 AM</b>
3 SEX <b>MALE</b>	4. RACE <b>WHITE</b>	5. DATE OF BIRTH <b>02-12-06</b>		6. AGE (In years last birthday) <b>62</b> YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN
7a. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <b>ALLEGANY</b> Md.		
10. CITY OR TOWN OF DEATH <b>CUMBERLAND</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>SACRED HEART HOSP</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>SUPERVISOR</b>	12b. KIND OF BUSINESS OR INDUSTRY <b>CLANFSE CORP</b>
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>W. VA.</b>		13b. COUNTY <b>M. NERAL</b>	13c. CITY OR TOWN <b>RIDGELEY</b>	13d. INSIDE CITY LIM TSP? <b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/>	13e. STREET AND NUMBER <b>11 POTOMAC AVENUE</b>
14. FATHER'S NAME First Middle Last <b>ROBERT BOBO</b>		15. MOTHER'S MAIDEN NAME First Middle Last <b>ANGEL NE HALTERMAN</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>NO</b> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. <b>214 07 5700</b>	17. INFORMANT <b>Mrs. Hilda Bobo</b> Address <b>Ridgeley, W. Va.</b> <b>HOSPITAL RECORD</b> <b>11 Potomac St.</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>superior Vena Cava Thrombosis 2 weeks</u> <b>10 d. 1</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Squamous cell carcinoma right lung</u> DUE TO, OR AS A CONSEQUENCE OF (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? <b>YES</b> <input type="checkbox"/> <b>NO</b> <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State		
22a. I certify that (I) (this hospital) attended the deceased from <u>3-21</u> , 19 <u>68</u> , to <u>4-10</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>4-9</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Dr. M. L. Miltenberger</u> DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22c. DATE SIGNED <u>11 Apr 68</u>	
22d. PHYSICIAN'S NAME (Type) <b>DR. MILTENBERGER</b>		22e. ADDRESS <b>5 POTOMAC ST., RIDGELEY W. VA.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>4/13/68</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Sunset Memorial Park</b>		23d. LOCATION (City or Town) (County) (State) <b>Cumberland Allegany, Md.</b>	
24. FUNERAL DIRECTOR <b>H. Wayne George</b>		ADDRESS <b>Cumberland, Md.</b>		25a. REC'D BY REGISTRAR <b>DR 15 1968</b>	25b. REGISTRAR'S SIGNATURE <u>John J. Judge</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

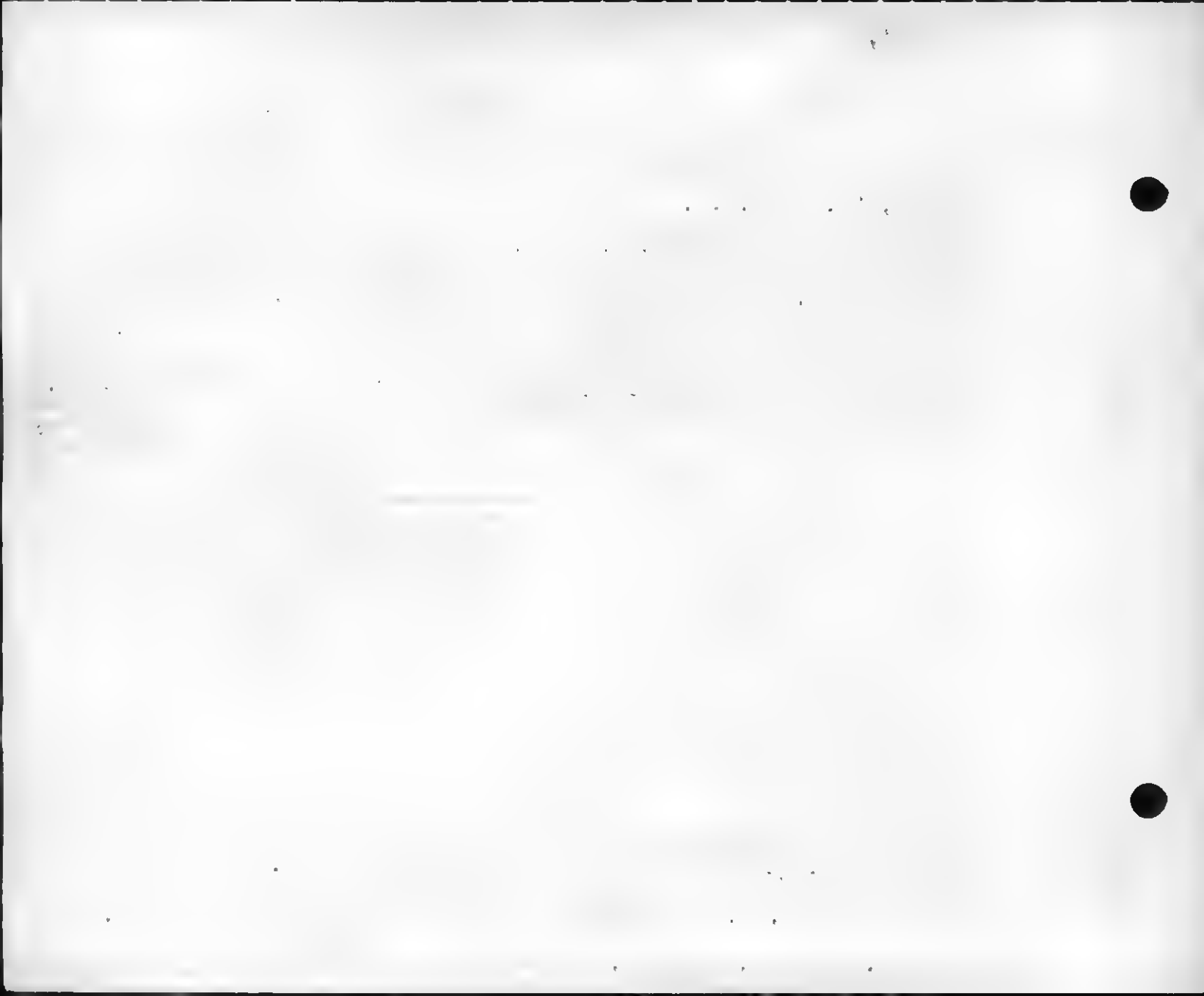
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH												
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												
CERTIFICATE OF DEATH												
1. DECEASED-NAME (Type or print)			First		Middle		Last		2a. DATE OF DEATH			2b. HOUR
GRANT			G		BOWER		Month 4 Day 11 Year 68			7:30 M		
3 SEX		4. RACE		5. DATE OF BIRTH				6. AGE (In years lost birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS
MALE		WHITE		12-9-10				57 YRS.		MONTHS DAYS		HOURS MIN.
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
HYNDMAN, PA.			U.S.A.					ALLEGANY Md				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY		
CUMBERLAND			MEMORIAL HOSPITAL				Bolt & Forge employee			B&ORR		
13a. USUAL RESIDENCE (Where deceased lived, if institution admission)			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER			
PENNSYLVANIA			BEDFORD		BUFFALO MILLS		NO		RT. 1			
14. FATHER'S NAME			First		Middle		Last		15. MOTHER'S MAIDEN NAME			
WILLIAM			BOWER		EMMA		EMERICK					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO.			17. INFORMANT			Address			
NO			214-09-0712			MEMORIAL HOSPITAL			CUMBERLAND, MD.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												
PART I. DEATH WAS CAUSED BY:												
IMMEDIATE CAUSE (a) <i>Cardiac Tamponade</i>												
DUE TO, OR AS A CONSEQUENCE OF												
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.												
(b) <i>Rupture of ventricular aneurysm</i>												
DUE TO, OR AS A CONSEQUENCE OF												
(c) <i>ASHD, EM &amp; AS and MI</i>												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)												
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH												
<i>instant</i>												
<i>instant</i>												
<i>3 wks</i>												
MEDICAL CERTIFICATION												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
			HOUR A.M. Month Day Year 19									
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY OFFICE BUILDING ETC)			21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE												
DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>												
22c. DATE SIGNED												
22d. PHYSICIAN'S NAME (Type) DR. V. DROSS												
22e. ADDRESS CUMBERLAND, MD.												
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)				
Burial			Apr. 13, 1968		Madley Cemetery			Buffalo Mills, Pa.		RD#1		
24. FUNERAL DIRECTOR												
ADDRESS												
Harvey H. Zeigler, Hyndman, Pennsylvania												
25a. REC'D BY REGISTRAR												
25b. REGISTRAR'S SIGNATURE												
APR 15 1968												



FOR STATE  
HEALTH DEPT

04967

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 DECEASED NAME (Type or Print) <b>THOMAS E. BUCY</b>			2a DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/> <b>APRIL 2, 1968</b>			2b HOUR <b>6:15 AM</b>	
3 SEX <b>MALE</b>	4 RACE <b>WHITE</b>	5 DATE OF BIRTH <b>JAN. 25, 1908</b>	6 AGE (in years last birthday) <b>60 YRS</b>	7 UNDER 1 YEAR MONTHS _____ DAYS _____	8 IF UNDER 24 HRS HOURS _____ MIN. _____	2c DATE PRONOUNCED DEAD <b>APRIL 2, 1968</b> Year 19 <b>6:30 AM</b>	
7a BIRTHPLACE (State or foreign country) <b>MD.</b>		7b CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>ALLEGANY</b> Md.	
10 CITY OR TOWN OF DEATH <b>CUMBERLAND</b>		11 NAME OF HOSPITAL OR INSTITUTION (If not a hospital give street address) <b>MEMORIAL HOSPITAL (DOA)</b>		12a SOCIAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>CARMAN</b>		12b KIND OF BUSINESS OR INDUSTRY <b>RAILROAD</b>	
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <b>MARYLAND</b>		13b COUNTY <b>ALLEGANY</b>		13c CITY OR TOWN <b>CUMBERLAND</b>		13d INSIDE CITY - M 15? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e STREET AND NUMBER <b>119 INDEPENDENCE STREET</b>							
14 FATHER'S NAME First Middle Last <b>HARRY V. BUCY</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>LOTTIE HENDRICKSON</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b>		16b SOCIAL SECURITY NO <b>214 07 1296</b>		17 INFORMANT ADDRESS <b>ETHEL BUCY, 119 INDEPENDENCE ST. CUMBERLAND MD.</b>			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>CORONARY OCCLUSION</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>CORONARY SCLEROSIS</b> DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>420</b>							
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY Month, Day, Year HOUR A.M. _____ P.M. <b>19</b>		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18)			
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f LOCATION Street or RFD No _____ City or Town _____ County _____ State _____			
22a I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <i>Benedict Skitarelic</i>		EXAMINER'S NAME (Type) <b>BENEDICT SKITARELIC, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ADDRESS (Street, city, town, or county)		22b DATE SIGNED <b>APRIL 2, 1968</b>	
23a BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b DATE <b>APRIL 4, 1968</b>		23c NAME OF CEMETERY OR CREMATORY <b>UNION GROVE CEMETERY</b>		23d LOCATION (City or Town) (County) (State) <b>CUMBERLAND ALLEGANY MD.</b>	
24 FUNERAL DIRECTOR <b>WILLIAM G. KIGHT</b>				ADDRESS <b>CUMBERLAND, MD.</b>		25a REC'D BY REGISTRAR DATE <b>APR 5 - 1968</b>	
				25b REGISTRAR'S SIGNATURE <i>Charles J. ...</i>			





TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
304A REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1. DECEASED NAME (Type or print)			First <b>RENA</b>		Middle <b>BUTLER</b>		Last <b>BUTLER</b>		2a. DATE OF DEATH Month <b>April</b> Day <b>22</b> Year <b>1968</b>	
3. SEX <b>FEMALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH <b>Sept. 28, 1892</b>			6. AGE (In years last birthday) <b>75</b> YRS.		7. IF UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b> HOURS <b>0</b> MIN <b>0</b>	
7a. BIRTHPLACE (State or foreign country) <b>Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Allegany</b> Md				
10. CITY OR TOWN OF DEATH <b>Frostburg</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Miner's Hospital</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>housekeeper</b>			12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE <b>Md.</b>			13b. COUNTY <b>Allegany</b>		13c. CITY OR TOWN <b>Frostburg</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <b>R.D.</b>	
14. FATHER'S NAME First <b>Chancie</b> Middle <b>Hoover</b> Last <b>Hoover</b>			15. MOTHER'S MAIDEN NAME First <b>Elmira</b> Middle <b>Bittinger</b> Last <b>Bittinger</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>No</b> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO <b>186-32-5549</b>		17. INFORMANT Address <b>Mrs. Marie Platter, Mt. Savage, Md.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac Failure</b> <b>2507</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>Interosselestatic C.V.D.</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Diabetes M.</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 days -</b> <b>years -</b> <b>years -</b>										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from <b>4/20, 1968</b> , to <b>4/22, 1968</b> , that (I) ( <del>we</del> ) last saw the deceased alive on <b>4/22, 1968</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) ( <del>we</del> ) (did) (did not) view the body after death.										
22b. SIGNATURE <b>John B. Davis</b>		DEGREE <b>M.D.</b>		ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>		
22d. PHYSICIAN'S NAME (Type) <b>JOHN B. DAVIS, M. D.</b>		22e. ADDRESS <b>2 BROADWAY, FROSTBURG, MD. 21532</b>								
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>4/25/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>New Germany M.E. Cem.</b>		23d. LOCATION (City or Town) (County) (State) <b>Grantsville, Garrett, Md.</b>				
24. FUNERAL DIRECTOR <b>Kush Newman</b>		ADDRESS <b>Grantsville, Md.</b>		25a. REC'D BY REGISTRAR <b>APR 29 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>				

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15-41  
30M REV 1-68

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH												
1. DECEASED-NAME (Type or print)			First		Middle		Last		2a. DATE OF DEATH		2b. HOUR	
EDWARD			L.		COLLINS				Month Day Year APRIL 3 68		12:45 P	
3 SEX			4 RACE			5 DATE OF BIRTH			6 AGE (In years last birthday)		7 UNDER 1 YEAR MONTHS DAYS	
MALE			WHITE			7-25-81			86 YRS.			
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH		Md.	
ORANGE, VA.			U.S.A.						AL LEGANY			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY			
CUMBERLAND			MEMORIAL HOSPITAL			Retired Engineer			Railroad			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
MARYLAND			ALEGANY			CUMBERLAND			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		129 HUMBIRD ST.	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME									
First Middle Last			First Middle Last									
Louis R. Collins			Nancy Michie									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT			Address			
no						MEMORIAL HOSPITAL			CUMBERLAND, MD.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Reversible Asthma</u> 4409 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>4500</u> (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 yr		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>2222 Sore Throat</u>												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION (Street or R.F.D. No. City or Town County State)						
22a. I certify that (I) (this hospital) attended the deceased from <u>4/7/68</u> , 19 <u>68</u> , to <u>4/9/68</u> , that (I) (we) last saw the deceased alive on <u>4/5/68</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE			DEGREE			ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>			22c. DATE SIGNED			
<u>DR. R. J. WILLIAMS</u>									<u>4/9/68</u>			
22d. PHYSICIAN'S NAME (Type)			22e. ADDRESS									
DR. R. J. WILLIAMS			CUMBERLAND, MD.									
23a. BURIAL CREMATION REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)			
Burial			Apr. 6, 1968			Sunset Memorial Park			Cumberland, Allegany, Md.			
24. FUNERAL DIRECTOR			ADDRESS			25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE			
James F. Scarpelli, Cumberland, Md.						DATE APR 9 - 1968			<u>Charles Judge</u>			

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 410-10  
30M REV. 1-58

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
**CERTIFICATE OF DEATH**

1 DECEASED NAME (Type or print) First <u>Idella</u> Middle <u>E</u> Last <u>Couter</u>			2a. DATE OF DEATH <u>Apr. 1</u> Month <u>18</u> Day <u>1968</u> Year			2b. HOUR <u>1:30</u> P. M.					
3 SEX <u>F</u>		4. RACE <u>W</u>		5. DATE OF BIRTH <u>4-8-84</u>		6. AGE (In years last birthday) <u>84</u> YRS.		IF UNDER 1 YEAR MONTHS <u>  </u> DAYS <u>  </u>		IF UNDER 24 HRS HOURS <u>  </u> MIN. <u>  </u>	
7a. BIRTHPLACE (State or foreign country) <u>md</u>		7b. CITIZEN OF WHAT COUNTRY? <u>America</u>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <u>Allegany</u> Md.					
10. CITY OR TOWN OF DEATH <u>Cumberland, md</u>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>Cumberland Nursing Center</u>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE <u>md</u>			13b. COUNTY <u>Allegany</u> <u>Cumberland</u>			13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <u>731 Elm St.</u>	
14. FATHER'S NAME First <u>George</u> Middle <u>Couter</u> Last <u>Margaret</u>			15. MOTHER'S MAIDEN NAME First <u>Margaret</u> Middle <u>Reid</u> Last <u>Reid</u>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <u>NO</u> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. <u>212-38-6488</u>			17. INFORMANT <u>Mrs. Ruth Pardee, Cumberland Md</u> Address <u>  </u>					
18. CAUSE OF DEATH (Enter only one cause per line, for (a), (b) and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>4129 Congestive Heart Failure</u>										2 years	
DUE TO, OR AS A CONSEQUENCE OF (b) <u>coronary sclerosis</u>										2 years	
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last (c) <u>arteriosclerosis</u>										3 years	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>  </u>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. <u>  </u> Month <u>  </u> Day <u>  </u> Year <u>19</u> P.M. <u>  </u>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. <u>  </u> City or Town <u>  </u> County <u>  </u> State <u>  </u>					
22a. I certify that (I) (this hospital) attended the deceased from <u>4-1-68</u> , 19 <u>68</u> , to <u>4-18</u> , 19 <u>68</u> , that (I) (we) lost saw the deceased alive on <u>4-6-68</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>H. Brings MD</u> DEGREE <u>  </u> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>						22c. DATE SIGNED <u>4-18-68</u>					
22d. PHYSICIAN'S NAME (Type) <u>L. BRINGS, M.D.</u>						22e. ADDRESS <u>Cumberland, Md</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>			23b. DATE <u>APRIL 21, 1968</u>			23c. NAME OF CEMETERY OR CREMATORY <u>ROSE HILL CEMETERY</u>			23d. LOCATION (City or Town) <u>CUMBERLAND, MD.</u> (County) <u>  </u> (State) <u>  </u>		
24. FUNERAL DIRECTOR <u>BYRON KIGHT</u> ADDRESS <u>CUMBERLAND, MD.</u>						25a. REC'D BY REGISTRAR <u>  </u> DATE <u>APR 22 1968</u>			25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV 1/68

<div style="text-align: center;"> <p>04971</p> <p>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</p> <p><b>CERTIFICATE OF DEATH</b></p> </div>												
1 DECEASED NAME (Type or print)			First		Middle		Last		2a. DATE OF DEATH		2b. HOUR	
WALTER			C.		CRAWFORD				APRIL Day 30, Year 68		P M	
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS		
MALE		COLORED		8-22-14		53 YRS		MONTHS DAYS		HOURS MIN		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH						
SO. CAROLINA		U S A				ALLEGANY				Md.		
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY			
CUMBERLAND			SACRED HEART HOSPITAL			TEACHER			EDUCATION SCHOOL			
13a. USAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER		
MARYLAND			ALLEGANY			CUMBERLAND		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		522 GREENE ST.		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME									
WALTER C. CRAWFORD			LULA WILLIAMS									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO			17 INFORMANT			Address			
YES			143-05-4538			PTS. HOSP RECORD			SACRED HEART HOSPITAL 900 SETON DRIVE CUMBERLAND			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))												
PART I. DEATH WAS CAUSED BY:												
IMMEDIATE CAUSE (a) <u>Subarachnoid hemorrhage</u>												
DUE TO, OR AS A CONSEQUENCE OF												
(b) <u>Hypertension</u>												
DUE TO, OR AS A CONSEQUENCE OF												
(c) <u>Generalized arteriosclerosis</u>												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)												
MEDICAL CERTIFICATION												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
						YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			yes			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)						
			HOUR A.M. Month Day Year P.M. 19									
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION			Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE									22c. DATE SIGNED			
Clarence F. Vincent - MD												
22d. PHYSICIAN'S NAME (Type)						22e. ADDRESS						
C. VINCENT						125 N. SMALLWOOD ST., CUMB., ; MD.						
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)		(State)		
Burial		5/3/68		Hickory Hill Burial Pk.		Cumberland		Md.				
24. FUNERAL DIRECTOR						25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE				
James Stein Inc. Cumb. Md.						DATE MAY 3 1968		Clarence F. Vincent				



# MARYLAND STATE DEPARTMENT OF HEALTH

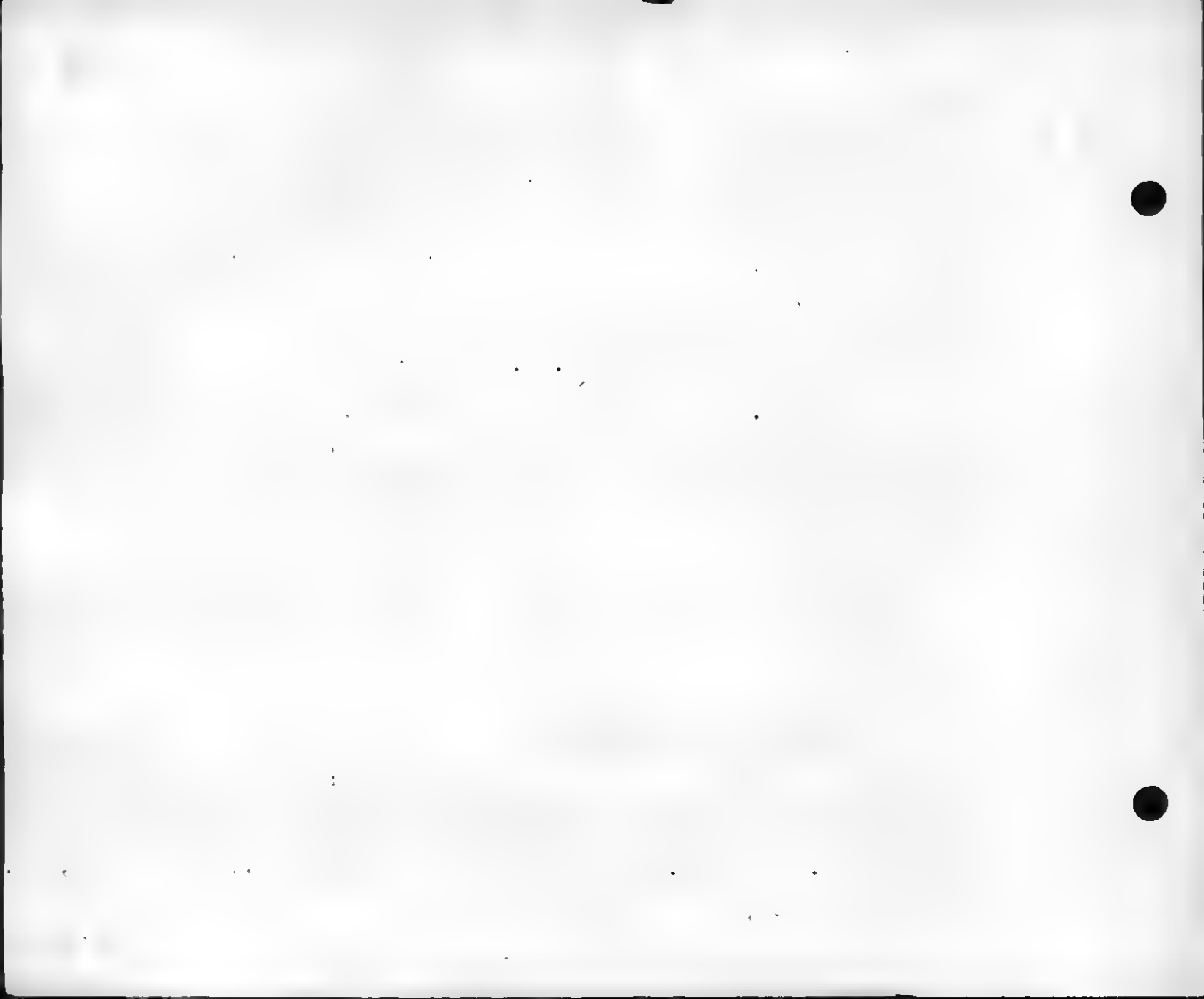
34972 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

04978

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		c. LENGTH OF STAY IN 1b <b>1 HR 20MIN</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>LA VALE</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>MEMORIAL HOSPITAL</b>		d. STREET ADDRESS <b>540 BRADDOCK AVENUE</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) First <b>DAVID</b> Middle <b>F</b> Last <b>DAVIS</b>		4 DATE OF DEATH Month <b>APRIL</b> Day <b>2</b> Year <b>19 68</b>	
5 SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>4-29-1920</b>
9 AGE (in years lost birthday) <b>47</b> yrs		10 UNDER 1 YEAR Months Days	11 UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Engineer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>B &amp; O R. R.</b>	
11 BIRTHPLACE (County & State, or foreign country) <b>WARREN, OHIO</b>		12 CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13 FATHER'S NAME <b>DAVID G. DAVIS</b>		14. MOTHER'S MAIDEN NAME <b>BESSIE I. BEAR</b>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes War II</b>		16. SOCIAL SECURITY NO <b>217-10-1126</b>	
17. INFORMANT <b>MEMORIAL HOSPITAL, CUMBERLAND, MD.</b>		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>C/A - Pancreas -</b> <b>1517</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) <b>1517</b>			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d INJURY OCCURRED While of work <input type="checkbox"/> Not While of work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at <b>12:50AM</b> causes and on the date stated above			
22a. SIGNATURE <b>DR. OLIVER H. NADEAU</b>		22b. DATES SIGNED <b>4-2-68</b>	
22c. PHYSICIAN'S NAME (Type) <b>DR. OLIVER H. NADEAU</b>		22d. ADDRESS <b>600 VIRGINIA AVE., CUMBERLAND, MD.</b>	
23a BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b DATE THEREOF <b>Apr. 4, 1968</b>	23c NAME OF CEMETERY OR CREMATORY <b>Sunset Memorial Park</b>	23d LOCATION (City or Town) (County) (State) <b>Cumberland, Md. Allegany</b>
24 FUNERAL DIRECTOR <b>James F. Scarpelli, Cumberland, Md.</b>		25a. RECD BY REGISTRAR DATE <b>APR 8 - 1968</b>	
		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.  
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV 1/68

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1 DECEASED NAME (Type or print)			First Middle Last			2a DATE OF DEATH			2b. HOUR		
ROYCE			WILLIAM			DAVIS			Month 4 - Day 20 - Year 68		
3. SEX			4 RACE			5 DATE OF BIRTH			6 AGE (In years last birthday)		
MALE			WHITE			AUG. 28th, 1965			2 YRS.		
7a. BIRTHPLACE (State or foreign country)			7b CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH		
MARYLAND			USA						ALLEGANY		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b KIND OF BUSINESS OR INDUSTRY		
FROSTBURG			MINERS HOSPITAL			NONE			NONE		
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE			13b. COUNTY			13c CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		
MARYLAND			ALLEGANY			CHUMBERLAND			542 FAIRMONT AVENUE		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME								
First Middle Last			First Middle Last								
FLOYD DAVIS			DAVIS			MARY			CLISE		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b SOCIAL SECURITY NO			17 INFORMANT			Address		
			NONE			MRS. FLOYD DAVIS, 542 FAIRMONT AVE. CUMB. MD.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Broncho pneumonia -</u>										2 days	
DUE TO, OR AS A CONSEQUENCE OF, (b) <u>Congenital defects -</u>											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) <u>Mongolian Baby -</u>										Birth	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
3254											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>			21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 4/18, 1968, to 4/20, 1968, that (I) <del>was</del> last saw the deceased alive on 4/20, 1968, and that in (my) <del>own</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>was</del> (did) <del>not</del> view the body after death.											
22b SIGNATURE			22c. PHYSICIAN'S NAME (Type)			22d. ADDRESS			22e. DATE SIGNED		
John B. Davis M.D.			JOHN B. DAVIS			2 BROADWAY, FROSTBURG, MD.			4/23/68		
23a BURIAL, CREMATION, REMOVAL (Specify)			23b DATE			23c NAME OF CEMETERY OR CREMATORY			23d LOCATION (City or Town) (County) (State)		
BURIAL			4-23-68			VALE SUMMIT CEMETERY			VALE SUMMIT, ALLEGANY, MD.		
24 FUNERAL DIRECTOR			25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE					
JOSEPH R. DURST,			FROSTBURG, MD.			DATE APR 25 1968			Charles Judge		

MEDICAL CERTIFICATION

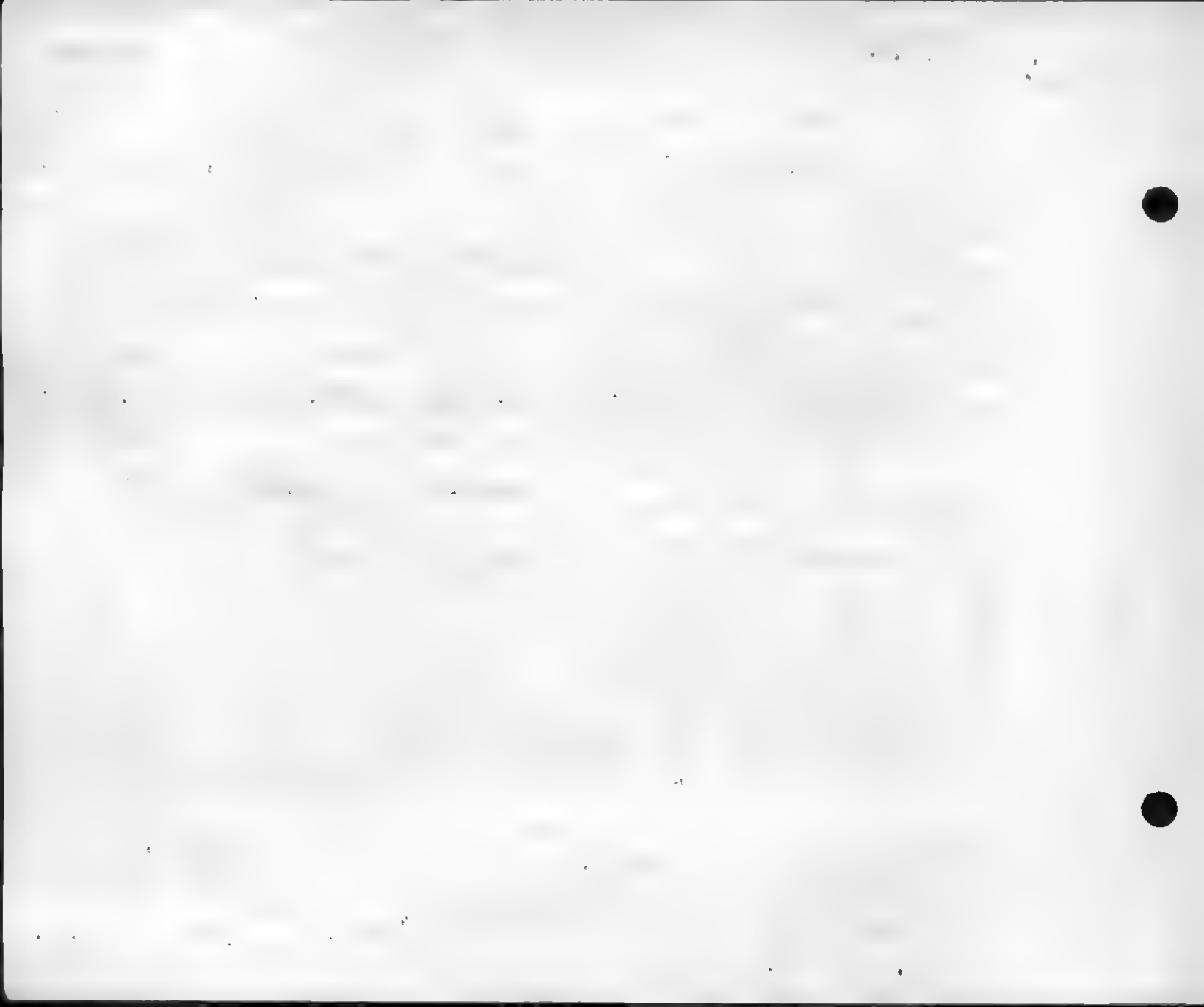




FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-1. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

<div>04976</div> <div> <div>1</div> <div>FOR STATE HEALTH DEPT.</div> </div> <div> <div>1</div> <div>TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-1. Page 5 may be retained for your files.</div> <div>TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.</div> </div>																			
<div>1. DECEASED-NAME (Type or Print)</div> <div>First Middle Last</div> <div>Virgil Lee Dean</div>						<div>2a. DATE KNOWN OF DEATH</div> <div>Month Day Year</div> <div>APRIL 22 1968</div>			<div>2b. HOUR OF DEATH</div> <div>7:45 PM</div>										
<div>3 SEX</div> <div>Male</div>		<div>4 RACE</div> <div>White</div>		<div>5 DATE OF BIRTH</div> <div>6 February 1927</div>		<div>6 AGE (in years last birthday)</div> <div>41 YRS</div>		<div>7 UNDER YEAR</div> <div>MONTHS DAYS HOURS MIN.</div>		<div>2c. DATE PRONOUNCED DEAD</div> <div>Month Day Year</div> <div>APRIL 22 1968</div>		<div>2d. HOUR OF DEATH</div> <div>7:45 PM</div>							
<div>7a. BIRTHPLACE (State or foreign country)</div> <div>Maryland</div>			<div>7b. CITIZEN OF WHAT COUNTRY?</div> <div>U S A</div>			<div>8 MARRIED</div> <div>NEVER MARRIED</div> <div>WIDOWED</div> <div>DIVORCED</div>			<div>9 COUNTY OF DEATH</div> <div>Allegany</div>			<div>12b. KIND OF BUSINESS OR INDUSTRY</div> <div>County Home</div>							
<div>10. CITY OR TOWN OF DEATH</div> <div>Cumberland</div>				<div>11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)</div> <div>Sylvan Retreat</div>				<div>12a. U.S.A. OCCUPATION (Kind of work done during most of working life, even if retired.)</div> <div>Orderly</div>				<div>12b. KIND OF BUSINESS OR INDUSTRY</div> <div>County Home</div>							
<div>13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE</div> <div>Maryland</div>				<div>13b. COUNTY</div> <div>Allegany</div>				<div>13c. CITY OR TOWN</div> <div>Cumberland</div>				<div>13d. INSIDE CITY LIMITS?</div> <div>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></div>				<div>13e. STREET AND NUMBER</div> <div>504 Decatur Street</div>			
<div>14 FATHER'S NAME</div> <div>First Middle Last</div> <div>Lee Porty Dean</div>						<div>15. MOTHER'S MAIDEN NAME</div> <div>First Middle Last</div> <div>Gertrude Nazelrod</div>													
<div>16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)</div> <div>Yes</div>				<div>16b. SOCIAL SECURITY NO</div> <div>236-36-1450</div>				<div>17 INFORMANT</div> <div>Mrs. Donna Lee Dean</div>				<div>ADDRESS</div> <div>Cumberland</div>							
<div>18 CAUSE OF DEATH (Enter on only one cause per line for (a), (b), and (c))</div> <div>PART 1. DEATH WAS CAUSED BY</div> <div>IMMEDIATE CAUSE (a)</div> <div>ACUTE FATTY LIVER</div> <div>511.0</div> <div>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last</div> <div>DUE TO, OR AS A CONSEQUENCE OF</div> <div>(b)</div> <div>ETHANOL</div> <div>DUE TO, OR AS A CONSEQUENCE OF</div> <div>(c)</div>												<div>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</div> <div>Days</div>							
<div>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)</div> <div>5811</div>																			
<div>19a. DATE OF OPERATION</div>				<div>19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?</div>				<div>20 AUTOPSY?</div> <div>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></div>											
<div>21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/></div> <div>CAUSE OF DEATH</div>				<div>21b. TIME OF INJURY Month, Day, Year</div> <div>HOUR A.M. P.M.</div> <div>19</div>				<div>21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)</div>											
<div>21d. INJURY OCCURRED</div> <div>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/></div>				<div>21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)</div>				<div>21f. LOCATION Street or R.F.D. No</div> <div>City or Town</div> <div>County</div> <div>State</div>											
<div>22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/></div>																			
<div>ACTUAL SIGNATURE</div> <div>Benedict Skitarelic</div> <div>EXAMINER'S NAME (Type)</div> <div>BENEDICT SKITARELIC, M.D.</div>						<div>CHIEF MEDICAL EXAMINER <input type="checkbox"/></div> <div>ASSISTANT MEDICAL EXAMINER <input type="checkbox"/></div> <div>DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/></div> <div>ADDRESS (Street, city, town, or county)</div> <div>CUMBERLAND, MARYLAND</div>						<div>22b. DATE SIGNED</div> <div>APRIL 22, 1968</div>							
<div>23a. BURIAL, CREMATION, REMOVAL (Specify)</div> <div>Burial</div>				<div>23b. DATE</div> <div>4/25/1968</div>				<div>23c. NAME OF CEMETERY OR CREMATORY</div> <div>Forest Glen Cemetery</div>				<div>23d. LOCATION (City or Town) (County) (State)</div> <div>Green Spring Mineral</div>							
<div>24. FUNERAL DIRECTOR</div> <div>John J. Hafer, Jr.</div>						<div>ADDRESS</div> <div>230 Balto Ave. Cumberland</div>						<div>25a. RECORD BY REGISTRAR</div> <div>APR 25 1968</div>		<div>25b. REGISTRAR'S SIGNATURE</div> <div>W. Va.</div>					

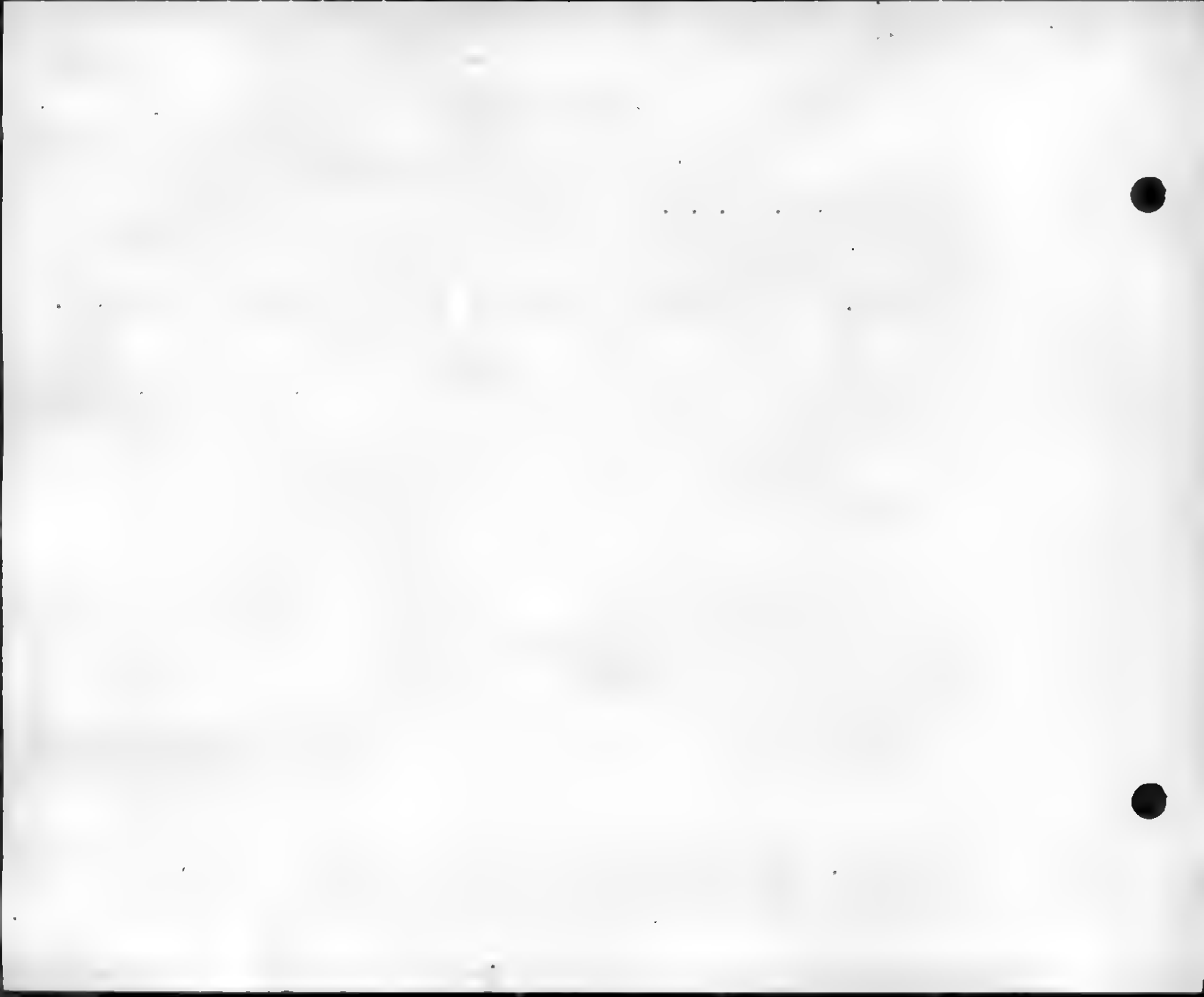


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1/68

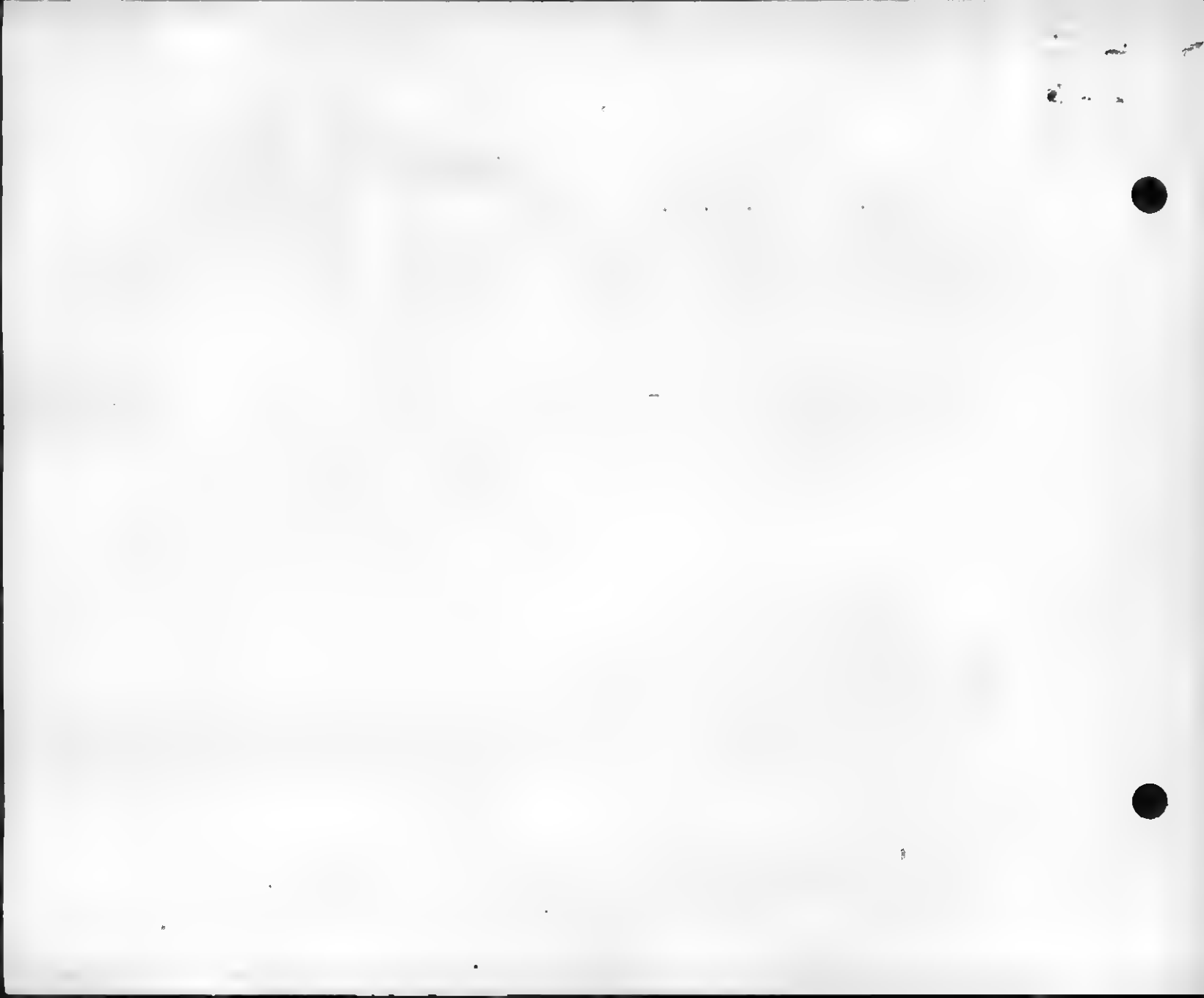
MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1 DECEASED NAME (Type or print) <b>FANNIE</b>			First Middle Last <b>Viola DEIBAUGH</b>			2a. DATE OF DEATH Month <b>APRIL</b> Day <b>3</b> Year <b>1968</b>		2b. HOUR P <b>11:50</b>		
3 SEX <b>FEMALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH <b>MARCH 10, 1886</b>		6. AGE In years last (day) <b>82</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (State or foreign country) <b>BEDFORD CO., PA.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>ALLEGANY</b> Md.				
10. CITY OR TOWN OF DEATH <b>CUMBERLAND</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>MEMORIAL HOSPITAL</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>HOUSEWIFE</b>		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>PENNA.</b>			13b. COUNTY <b>BEDFORD</b>		13c. CITY OR TOWN <b>BEDFORD</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <b>ROUTE 3, BEDFORD, PA.</b>	
14. FATHER'S NAME First Middle Last <b>ABIA AKERS</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>SARAH WINCK</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <b>No</b> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO <b>182-22-183</b>		17. INFORMANT Address <b>MEMORIAL HOSPITAL, CUMBERLAND, MARYLAND</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Mt. status Carcinoma with origin in</b> <b>1541</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>rectum</b> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 yrs.</b>										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) <b>154X 80 yrs.</b>										
19a. DATE OF OPERATION <b>2 yrs</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Carcinoma Rectum</b>			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <b>1966</b> , 19__, to <b>4-3</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>4-2</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>Carlton Brinsfield</b>					DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>4-5-68</b>			
22d. PHYSICIAN'S NAME (Type) <b>DR. CARLTON BRINSFIELD</b>					22e. ADDRESS <b>401 DECATUR STREET, CUMBERLAND, MD</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>4/7/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Everett Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Everett, Bedford Co., Pa.</b>				
24. FUNERAL DIRECTOR <b>Lyndell V. Conner</b>					ADDRESS <b>Everett, Pa.</b>		25a. REC'D BY REGISTRAR DATE <b>APR 9 - 1968</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201																	
Item # 5 & 6 Film # G.O. 5/31/68 Item # 13c Film # G.O. 5/22/68 Item # 13c Film # G.O. 5/31/68																	
CERTIFICATE OF DEATH																	
1. DECEASED-NAME (Type or print)			First HENRY			Middle A.			Last DOMAN			2a. DATE OF DEATH APRIL Month Day 1968			2b. HOUR 4:45 PM		
3. SEX MALE			4. RACE WHITE			5. DATE OF BIRTH 9/23/1890			6. AGE (In years lost birthday) 77 YRS			IF UNDER 1 YEAR MONTHS DAYS			IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (State or foreign country) W.VA.			7b. CITIZEN OF WHAT COUNTRY? U. S. A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH ALLEGANY Md.								
10. CITY OR TOWN OF DEATH CUMBERLAND			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) MEMORIAL HOSPITAL			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) none			12b. KIND OF BUSINESS OR INDUSTRY								
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE MD.			13b. COUNTY ALLEGANY			13c. CITY OR TOWN CUMBERLAND			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER					
14. FATHER'S NAME First Unknown			Middle DOMAN			Last DOMAN			15. MOTHER'S MAIDEN NAME First Susan			Middle Doman			Last Doman		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) no			16b. SOCIAL SECURITY NO. 220-10-2290A			17. INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MD.						Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CVA</u> <u>4129</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <u>Generalized Arteriosclerotic Heart Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u>																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 1968			21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)											
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State											
22a. I certify that (I) (this hospital) attended the deceased from <u>June 1968</u> to <u>April 14, 1968</u> , that (I) (we) last saw the deceased alive on <u>April 14, 1968</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																	
22b. SIGNATURE <u>B. M. Schindler</u>			DEGREE DR. B. SCHINDLER			ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED <u>4/25/68</u>								
22d. PHYSICIAN'S NAME (Type)			22e. ADDRESS CUMBERLAND, MD.														
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE <u>4/27/68</u>			23c. NAME OF CEMETERY OR CREMATORY <u>Laurel Hill Cemetery</u>			23d. LOCATION (City or Town) (County) (State) <u>Moscow A. Md</u>								
24. FUNERAL DIRECTOR <u>George Eichhorn</u>			ADDRESS <u>Lonaconing, Md.</u>			25a. REC'D BY REGISTRAR DATE <u>APR 29 1968</u>			25b. REGISTRAR'S SIGNATURE <u>Charles J. J...</u>								



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

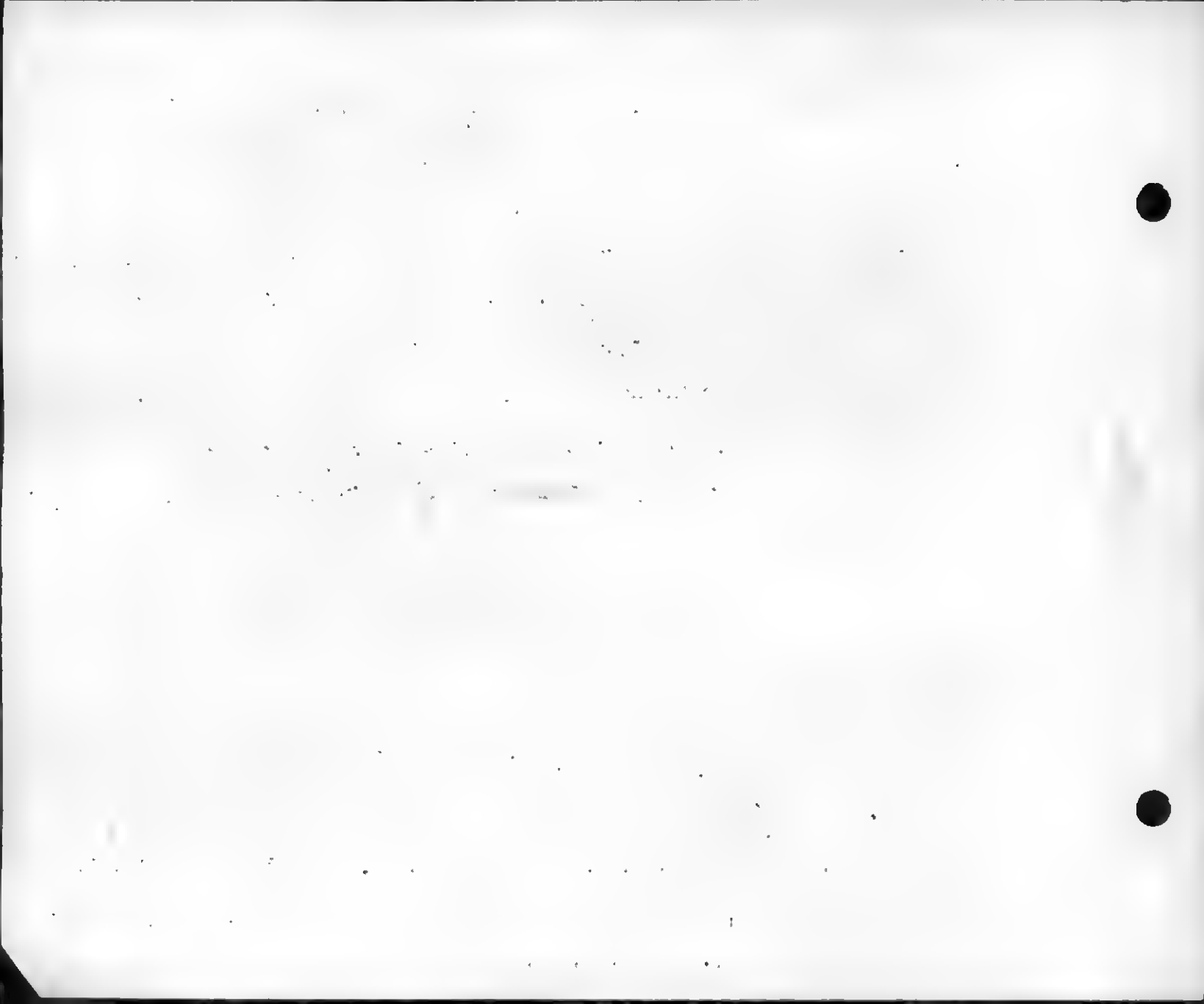
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (Pages 1 and 2) should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

1 DECEASED NAME (Type or print) <b>LINNIE</b>		First <b>E.</b>		Middle <b>FIKE</b>		Last <b>FIKE</b>		2a DATE OF DEATH Month <b>APRIL</b> Day <b>1</b> Year <b>1968</b>		2b HOUR <b>M</b>	
3 SEX <b>FEMALE</b>		4 RACE <b>WHITE</b>		5 DATE OF BIRTH <b>APRIL 7, 1883</b>		6 AGE (In years lost birthday) <b>84</b> YRS.		7 UNDER 1 YEAR MONTHS		8 UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH <b>ALLEGANY</b> Md.					
10 CITY OR TOWN OF DEATH <b>FROSTBURG</b>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>MINERS HOSPITAL</b>		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>HOUSE WORK</b>		12b KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>					
13a USUAL RESIDENCE (Where deceased lived, if institution residence before admission) <b>MARYLAND</b>		13b. COUNTY <b>ALLEGANY</b>		13c CITY OR TOWN <b>FROSTBURG</b>		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>124 McCULLOH STREET</b>			
14 FATHER'S NAME <b>HENRY</b>		First <b>WEITZELL</b>		Middle <b>WEITZELL</b>		Last <b>WEITZELL</b>		15 MOTHER'S MAIDEN NAME <b>FANNIE</b>		Middle <b>STARK</b>	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)		(If yes give war or dates of service)		16b. SOCIAL SECURITY NO <b>216-46-5200</b>		17. INFORMANT Address <b>MRS. LAURA EICHORN, FROSTBURG, MD.</b>					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>MASSIVE MYOCARDIAL INFARCTION</b> <b>4109</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>CHRONIC ARTERIOSCLEROTIC HEART DISEASE</b> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>60 days</b>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from <b>Jan. 25, 1968</b> to <b>APRIL 1, 1968</b> , that (I) (we) last saw the deceased alive on <b>APRIL 1, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>S. Paige Strong, M.D.</b>		DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>4/2/68</b>	
22d. PHYSICIAN'S NAME (Type) <b>A. PAIGE STRONG, M. D.</b>		22e. ADDRESS <b>167 E. MAIN ST., FROSTBURG, MD. 21532</b>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE <b>APRIL 4 '68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>WEITZELL CEMETERY</b>		23d. LOCATION (City or Town) (County) (State) <b>GARRETT, MARYLAND</b>					
24. FUNERAL DIRECTOR <b>JOSEPH R. DURST, SR., FROSTBURG, MD.</b>		25a. REC'D BY REGISTRAR DATE <b>APR 8 - 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>							





FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Fill in pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 DECEASED NAME (Type or Print) <b>ORAN FLESHER</b>		2a DATE KNOWN OF DEATH MATED <input checked="" type="checkbox"/> Month Day Year <b>APRIL 7, 1968</b>		2b HOUR <b>3:30</b> M
3 SEX <b>MALE</b>	4 RACE <b>WHITE</b>	5 DATE OF BIRTH <b>OCT. 30, 1903</b>	6 AGE (In years last birthday) <b>64</b> YRS	7c DATE PRONOUNCED DEAD Month Day Year <b>APRIL 7, 1968</b>
7a BIRTHPLACE (State or foreign country) <b>PENNA.</b>		7b CITIZEN OF WHAT COUNTRY? <b>USA</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
10 CITY OR TOWN OF DEATH <b>CUMBERLAND</b>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>214 COLUMBIA STREET</b>		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>ELEVATOR OPERATOR</b>
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <b>MARYLAND</b>		13b COUNTY <b>ALLEGANY</b>		13c CITY OR TOWN <b>CUMBERLAND</b>
14 FATHER'S NAME First Middle Last <b>DENNIS FLESHER</b>		15 MOTHER'S MAIDEN NAME First Middle Last <b>BERTHA McCLINTOCK</b>		13d AS TO CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16b SOCIAL SECURITY NO <b>UNKNOWN</b>		17 INFORMANT ADDRESS <b>MRS. FRANCES FLESHER CUMBERLAND, MD.</b>
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>CORONARY OCCLUSION</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <b>CORONARY SCLEROSIS</b> DUE TO, OR AS A CONSEQUENCE OF (c)				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>SUDDEN</b>
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)				
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED?		20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY Month Day Year HOUR A.M. P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 Item 18)
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f LOCATION Street or R.F.D. No City or Town County State
22a I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>				
ACTUAL SIGNATURE <b>Benedict Skitarelic</b> M.D. EXAMINER'S NAME (Type) <b>BENEDICT SKITARELIC, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b DATE SIGNED <b>APRIL 7, 1968</b>
23a BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b DATE <b>APRIL 10, 1968</b>		23c NAME OF CEMETERY OR CREMATORY <b>ROSE HILL CEMETERY</b>
24 FUNERAL DIRECTOR <b>BYRON KIGHT</b>		ADDRESS <b>CUMBERLAND, MD.</b>		23d LOCATION (City or Town) (County) (State) <b>CUMBERLAND, ALLEGANY MD.</b>
25a RECEIVED BY REGISTRAR <b>APR 11 1968</b>		25b REGISTRAR'S SIGNATURE <i>Charles Judge</i>		



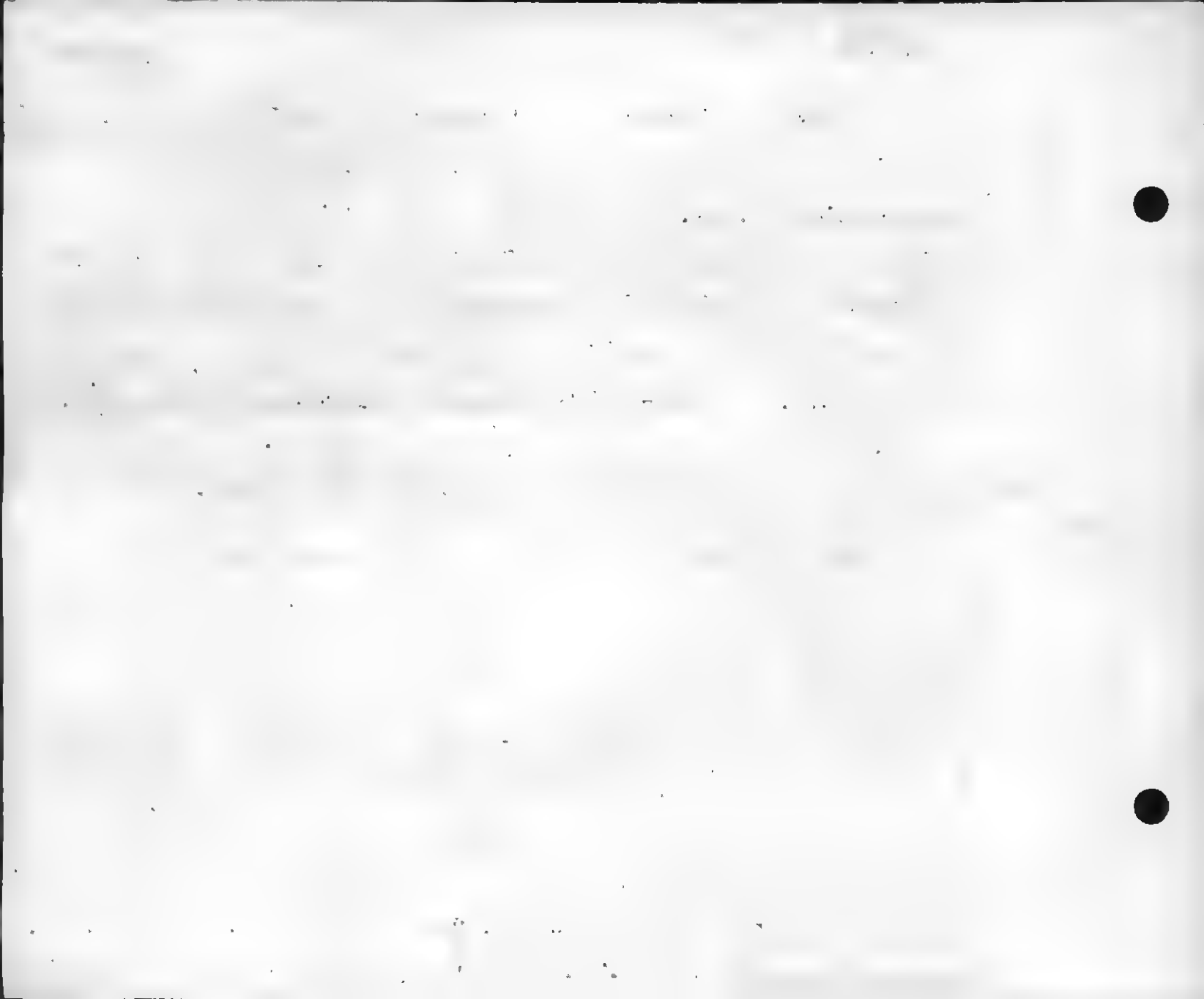
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14

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**  
**CERTIFICATE OF DEATH**

1. DECEASED-NAME (Type or print) <b>SARAH GRINDEL FRANKLIN</b>			2a. DATE OF DEATH Month <b>APRIL</b> Day <b>20</b> Year <b>1968</b>			2b. HOUR <b>3:30</b>	
3. SEX <b>FEMALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH <b>NOVEMBER 13, 1880</b>		6. AGE (In years last birthday) <b>87</b> YRS	
7a. BIRTHPLACE (State or foreign country) <b>COAL CITY, ILL.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>ALLEGANY</b>	
10. CITY OR TOWN OF DEATH <b>FROSTBURG</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>101 McCULLOH STREET</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission). STATE <b>MARYLAND</b>		13b. COUNTY <b>ALLEGANY</b>		13c. CITY OR TOWN <b>FROSTBURG</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME First <b>ROBERT</b> Middle <b>WHITE</b> Last <b>JANE</b>		15. MOTHER'S MAIDEN NAME First <b>JANE</b> Middle <b>NESBIT</b> Last <b>NESBIT</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>N.A.</b>		17. INFORMANT <b>FROSTBURG, MD.</b> <b>MISS JANE GRINDEL, 101 McCULLOH ST.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Atherosclerotic Heart Disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>15 yrs</b>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or RFD No City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <b>3/27</b> , 19 <b>66</b> , to <b>4/20</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>4/18/68</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Wayne F. Stagle</b>		DEGREE <b>MD</b>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>4/22/68</b>	
22d. PHYSICIAN'S NAME (Type) <b>WAYNE F. STAGLE</b>		22e. ADDRESS <b>127 N SMALLWOOD CAMPBELL AVE</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE <b>4/23/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>FROSTBURG MEM. PARK</b>		23d. LOCATION (City or Town) (County) (State) <b>FROSTBURG, ALLEGANY, MD.</b>	
24. FUNERAL DIRECTOR <b>MARILYN M. SOWERS</b>		25a. REC'D BY REGISTRAR <b>APR 25 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles J. Jones</b>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MD 980

1981

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

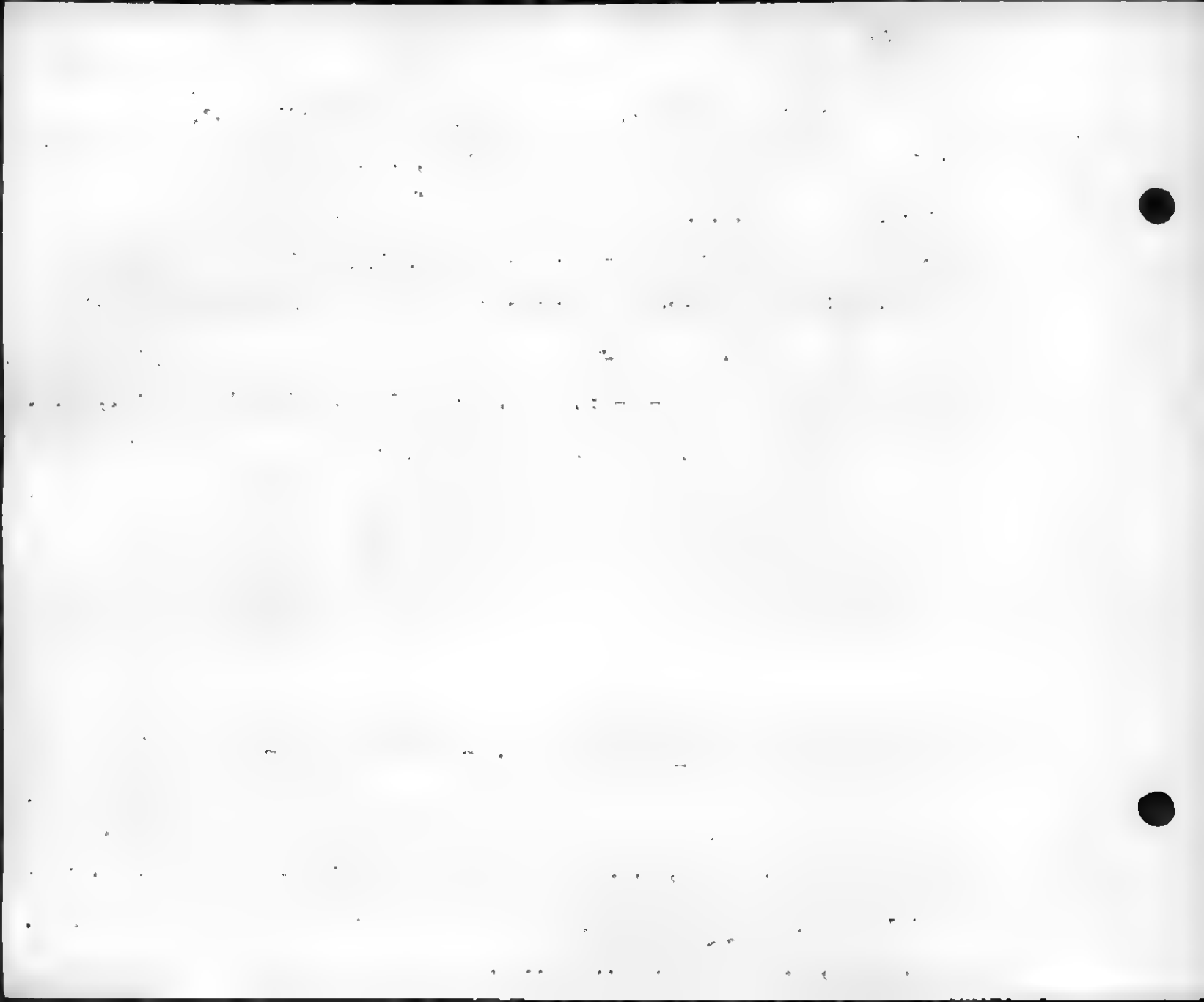
1. DECEASED NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH Month Day Year		2b. HOUR	
CLARA		O		GAYHART	4 30 68		10:10 A M	
3 SEX FEMALE		4. RACE WHITE		5 DATE OF BIRTH 6-28-93		6. AGE (In years last birthday) 74 YRS.		IF UNDER 1 YEAR MONTHS DAYS
7a BIRTHPLACE (State or foreign country) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH ALLEGANY Md.		
10 CITY OR TOWN OF DEATH CUMBERLAND		11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) MEMORIAL HOSPITAL		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY OWN HOME		
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE MARYLAND		13b. COUNTY ALLEGANY		13c. CITY OR TOWN CUMBERLAND		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 214 SOUTH LEE ST.
14 FATHER'S NAME WILLIAM		First Middle Last SMITH		5 MOTHER'S MAIDEN NAME CATHERINE		First Middle Last KING		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown NO		16b. SOCIAL SECURITY NO UNKNOWN		17 INFORMANT MEMORIAL HOSPITAL		Address CUMBERLAND, MD.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Intra-abdominal Carcinomatosis</u> 1061 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Carcinoma of bile duct or pancreas</u> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 days								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Diabetes Mellitus</u>								
19a. DATE OF OPERATION 4/24/68		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Abdominal mass		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
21a. INJURY OCCURRED While <input type="checkbox"/> Nat. while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21b. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21c. LOCATION Street or R.F.D. No City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from 4/21, 1968, to 4/30, 1968, that (I) (we) last saw the deceased alive on 4/30, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE Andrew Stasko MD		DEGREE		ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED 5/3/68		
22d. PHYSICIAN'S NAME (Type) DR. CLAY DURRETT		22e. ADDRESS CUMBERLAND, MD.						
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE MAY 3, 1968		23c. NAME OF CEMETERY OR CREMATORY HILLCREST BURIAL PARK		23d. LOCATION (City or Town) (County) (State) CUMBERLAND, MD.		
24. FUNERAL DIRECTOR BYRON KIGHT		ADDRESS CUMBERLAND, MD.		25a. REC'D. BY REGISTRAR DATE MAY 6 1968		25b. REGISTRAR'S SIGNATURE Johnas Judge		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1 DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH Month Day Year		2b HOUR	
Effie Watson George						April 13, 1968		4 PM	
3 SEX		4 RACE		5. DATE OF BIRTH		6 AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
Female		White		March 20, 1894		74 YRS			
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		Md	
Maryland		U.S.A.				Allegany			
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY			
Cumberland		304 Cumberland Street		Office Work		Laundry			
13a. US. AL RESIDENCE (Where deceased lived, if institut on Residence before admission) STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER	
Maryland		Allegany		Cumberland				304 Cumberland Street	
14 FATHER'S NAME First Middle Last			15 MOTHER'S MAIDEN NAME First Middle Last						
John S. George			Mary Stevenson						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		(If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT Address			
No				214-05-6282		Mrs. George Durst, 304 Cumberland St., Cumb.Md			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure								5 mos	
DUE TO, OR AS A CONSEQUENCE OF									
(Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.)									
(b) Coronary Heart Disease								4 years	
DUE TO, OR AS A CONSEQUENCE OF									
(c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
9a DATE OF OPERATION		9b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC)		21f. LOCATION Street or R.F.D. No.		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from 2 - 55, 19, to 4 - 14, 19 68 that (I) (we) last saw the deceased alive on 4 - 3, 19 68, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b SIGNATURE		22c. DATE SIGNED		22e. ADDRESS		22f. REGISTRAR'S SIGNATURE			
Ralph W. Ballin		April 15, 1968		62 Greene Street, Cumberland, Md. 21502		Charles Judge			
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS		22f. REGISTRAR'S SIGNATURE		22g. REGISTRAR'S SIGNATURE			
Ralph W. Ballin, M.D.		62 Greene Street, Cumberland, Md. 21502							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		4/16/68		Hillcrest Burial Park		Near Cumberland, Allegany, Md.			
24 FUNERAL DIRECTOR		24a. ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
John J. Hafer, Jr.		280 Balto. Ave., Cumb., Md.		DATE APR 17 1968		Charles Judge			





## CERTIFICATE OF DEATH

23

1. DECEASED NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH Month Day Year		2b. HOUR	
JOHN			M.	GORNALL	11 6 68		5:25 PM	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN
MALE		WHITE		12-7-01		66 YRS.		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		
CUMBERLAND, MD.		U.S.A.				ALLEGANY Md.		
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY		
CUMBERLAND		MEMORIAL HOSPITAL		RETIRED		RETAIL STORE		
13a. USUAL RESIDENCE (Where deceased lived, if institution or residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER
MARYLAND		ALLEGANY		CUMBERLAND				775 MC DONALD TERRACE
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME						
First Middle Last		First Middle Last						
WILLIAM F. GORNALL		FLORA GANDY						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO.		17. INFORMANT Address				
NO				MEMORIAL HOSPITAL CUMBERLAND, MD.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY:								
IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u>								5
4101 DUE TO, OR AS A CONSEQUENCE OF								
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last								
(b) DUE TO, OR AS A CONSEQUENCE OF								
(c)								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)								
420								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
		19						
21a. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21b. PLACE OF INJURY (At home farm street factory, office building etc.)		21f. LOCATION Street or R.F.D. No City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from 4-5-1968, to 4-6-1968, that (I) (we) last saw the deceased alive on 4-6-1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE		DEGREE		ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED		
DR. W. F. WILLIAMS						4-8-68		
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS						
DR. W. F. WILLIAMS		CUMBERLAND, MD.						
23a. BURIAL CREMATION REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)		
Burial		Apr. 9, 1968		SS. Peter & Paul Cemetery		Cumberland, Allegany, Md.		
24. FUNERAL DIRECTOR		James P. Scarpelli, Cumberland, Md.		25a. REC'D BY REGISTRAR DATE		25b. REGISTRAR'S SIGNATURE		
				APR 9 - 1968		Charles Judge		

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

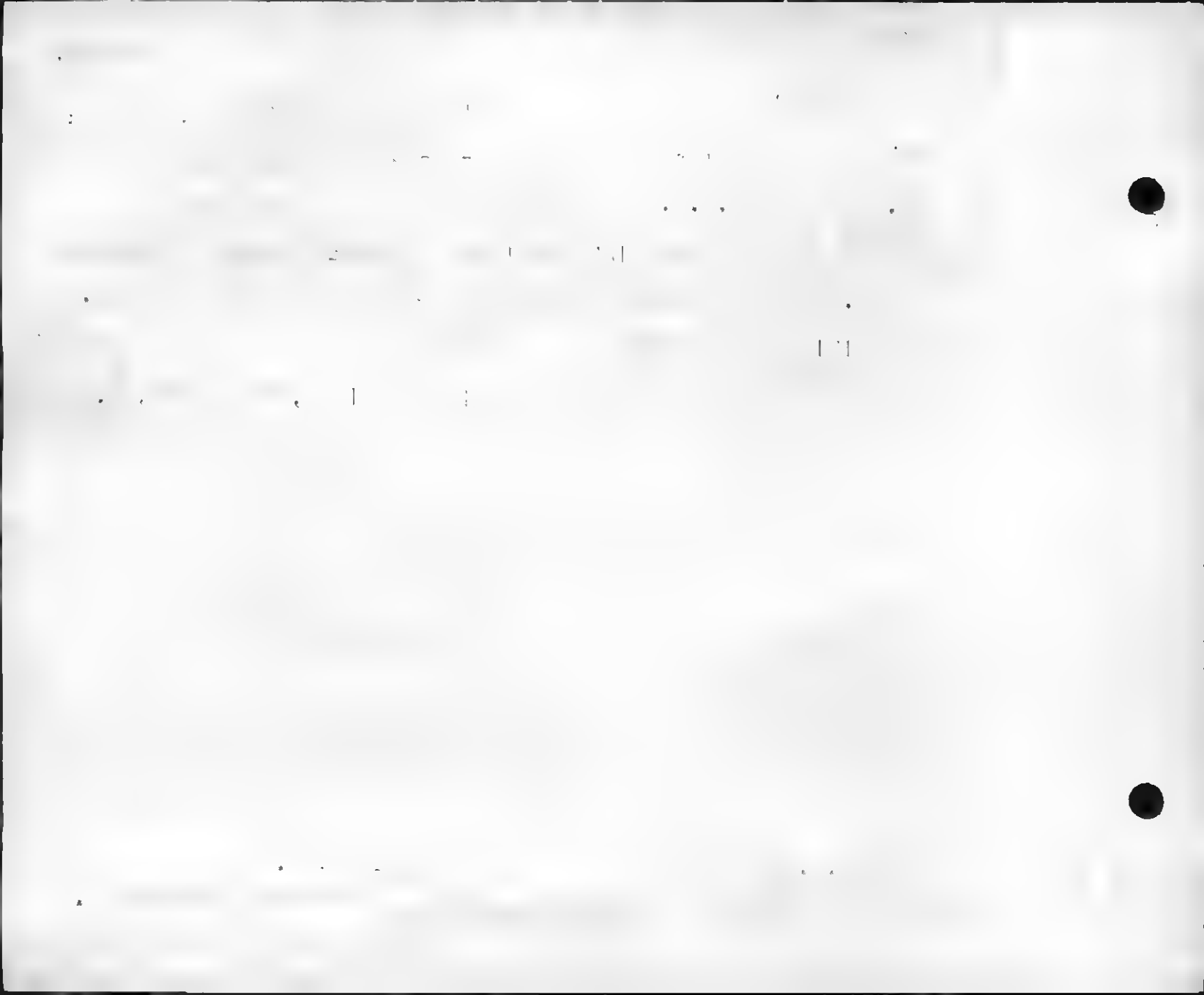
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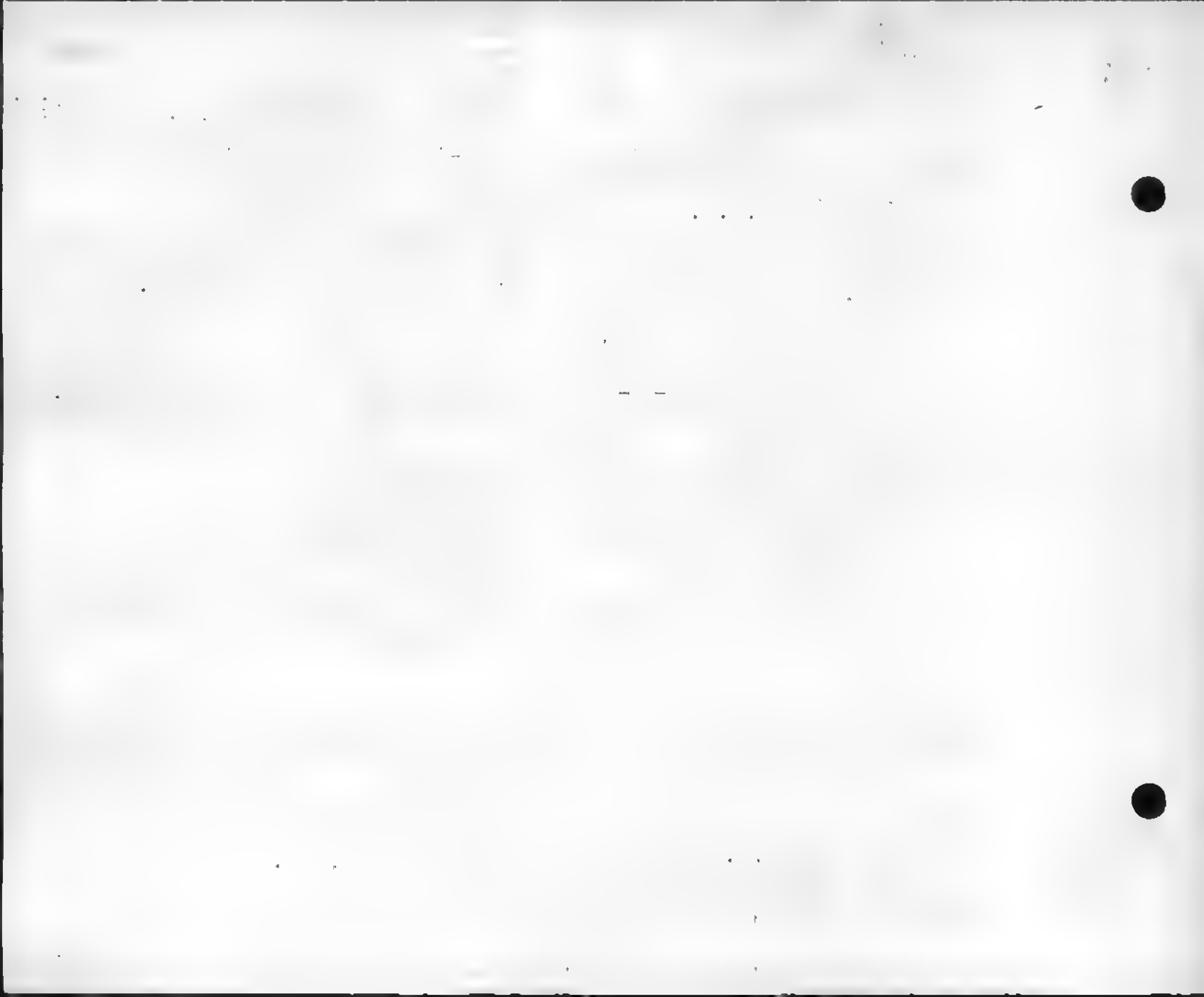
MARYLAND STATE DEPARTMENT OF HEALTH																	
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201																	
CERTIFICATE OF DEATH																	
1. DECEASED-NAME (Type or print)			First <b>PHILIP</b>			Middle <b>HARTIG</b>			Last <b>HARTIG</b>			2a. DATE OF DEATH Month <b>APRIL</b> Day <b>7</b> Year <b>1968</b>			2b. HOUR <b>8:31<sup>PM</sup></b>		
3 SEX <b>MALE</b>			4. RACE <b>WHITE</b>			5. DATE OF BIRTH <b>2-12-1898</b>			6. AGE (In years last birthday) <b>70</b> YRS.			IF UNDER 1 YEAR MONTHS <b>70</b> DAYS <b>70</b>			IF UNDER 24 HRS. HOURS <b>70</b> MIN <b>70</b>		
7a. BIRTHPLACE (State or foreign country) <b>MD.</b>			7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <b>ALLEGANY</b> Md.								
10 CITY OR TOWN OF DEATH <b>CUMBERLAND</b>			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>MEMORIAL HOSPITAL</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Surveying engineer</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>Surveying</b>								
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MD.</b>			13b. COUNTY <b>ALLEGANY</b>			13c. CITY OR TOWN <b>WESTERNPORT</b>			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER <b>315 MARYLAND AVE.</b>					
14. FATHER'S NAME First <b>PHILIP</b>			Middle <b>HARDY</b>			Last <b>ELIZABETH</b>			15. MOTHER'S MAIDEN NAME First <b>ELIZABETH</b>			Middle <b>STRUBY</b>			Last <b>STRUBY</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, <b>no</b> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO <b>214 05 8705</b>			17 INFORMANT <b>MEMORIAL HOSPITAL, CUMBERLAND, MD.</b>						Address					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage with left hemiplegia</b> <b>4:31 P.M.</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 1/2 days</b>																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>1 X</b>																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)											
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State											
22a. I certify that (I) (this hospital) attended the deceased from <b>5 Apr. 1968</b> , to <b>7 Apr. 1968</b> , that (I) (we) last saw the deceased alive on <b>7 Apr. 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																	
22b. SIGNATURE <b>W. Alfred Van Ormer, M.D.</b>			DEGREE			ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED <b>8 Apr. 68</b>								
22d. PHYSICIAN'S NAME (Type) <b>DR. W. VAN ORMER</b>			22e. ADDRESS <b>CUMBERLAND, MD.</b>														
23a. BURIAL, CREMATION, REMAIN (Specify)			23b. DATE <b>4/11/68</b>			23c. NAME OF CEMETERY OR CREMATORY <b>FROSTBURG MEMORIAL PARK</b>			23d. CITY OR TOWN <b>FROSTBURG ALLEGANY Md.</b> (State)								
24. FUNERAL DIRECTOR <b>E. J. Boal</b>			ADDRESS <b>Westernport, Md.</b>			25a. REC'D BY REGISTRAR <b>APR 11 1968</b>			25b. REGISTRAR'S SIGNATURE <b>J. J. Judge</b>								



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH																				
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201																				
CERTIFICATE OF DEATH																				
1. DECEASED-NAME (Type or print)			First <b>RAYMOND</b>			Middle <b>E</b>			Last <b>HENRY</b>			2a. DATE OF DEATH Month <b>APRIL</b> Day <b>29</b> Year <b>1968</b>			2b. HOUR <b>P.M.</b> 11:06					
3 SEX <b>MALE</b>			4. RACE <b>WHITE</b>			5. DATE OF BIRTH <b>12-17-1886</b>			6. AGE (In years lost birthday) <b>81</b> YRS			IF UNDER 1 YEAR MONTHS <b>81</b> DAYS <b>81</b> HOURS <b>81</b> MIN.			IF UNDER 24 HRS HOURS <b>81</b> MIN.					
7a. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>			7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <b>ALLEGANY</b>			Md.								
10. CITY OR TOWN OF DEATH <b>CUMBERLAND</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>MEMORIAL HOSPITAL</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>RETIRED MAINTENANCE</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>CELANESE</b>											
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MD.</b>			13b. COUNTY <b>ALLEGANY</b>			13c. CITY OR TOWN <b>FROSTBURG</b>			13d. INSIDE CITY LIMITS? <b>X</b> YES <input type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER <b>168 SPRING ST.</b>								
14. FATHER'S NAME First <b>GEORGE</b>			Middle <b>HENRY</b>			Last <b>ROSS</b>			15. MOTHER'S MAIDEN NAME First <b>NORA</b>			Middle <b>ROSS</b>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO <b>214-07-5037</b>			17. INFORMANT <b>MEMORIAL HOSPITAL, CUMBERLAND, MD.</b>			Address											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Mesenteric artery thrombosis</b> <b>4124</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <b>arteriosclerosis</b> DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Coronary artery disease</b>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>30 hours</b>								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?											
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)														
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State														
22a. I certify that (I) (this hospital) attended the deceased from <b>28 April, 1968</b> to <b>29 April, 1968</b> , that (I) (we) last saw the deceased alive on <b>29 April, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.																				
22b. SIGNATURE <b>Dr. S.G. Weisman</b>												DEGREE <b>MD.</b>			ATTENDING PHYSICIAN <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED <b>5/1/68</b>		
22d. PHYSICIAN'S NAME (Type) <b>DR. S.G. WEISMAN</b>												22e. ADDRESS <b>CUMBERLAND, MD.</b>								
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>			23b. DATE <b>MAY 2 '68</b>			23c. NAME OF CEMETERY OR CREMATORY <b>LOAR CEMETERY</b>			23d. LOCATION (City or Town) (County) (State) <b>LOARTOWN, ALLEGANY, MD.</b>											
24. FUNERAL DIRECTOR <b>JOSEPH R. DURST, SR., FROSTBURG, MD. 21532</b>												25a. REC'D BY REGISTRAR DATE <b>MAY 6 1968</b>			25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>					



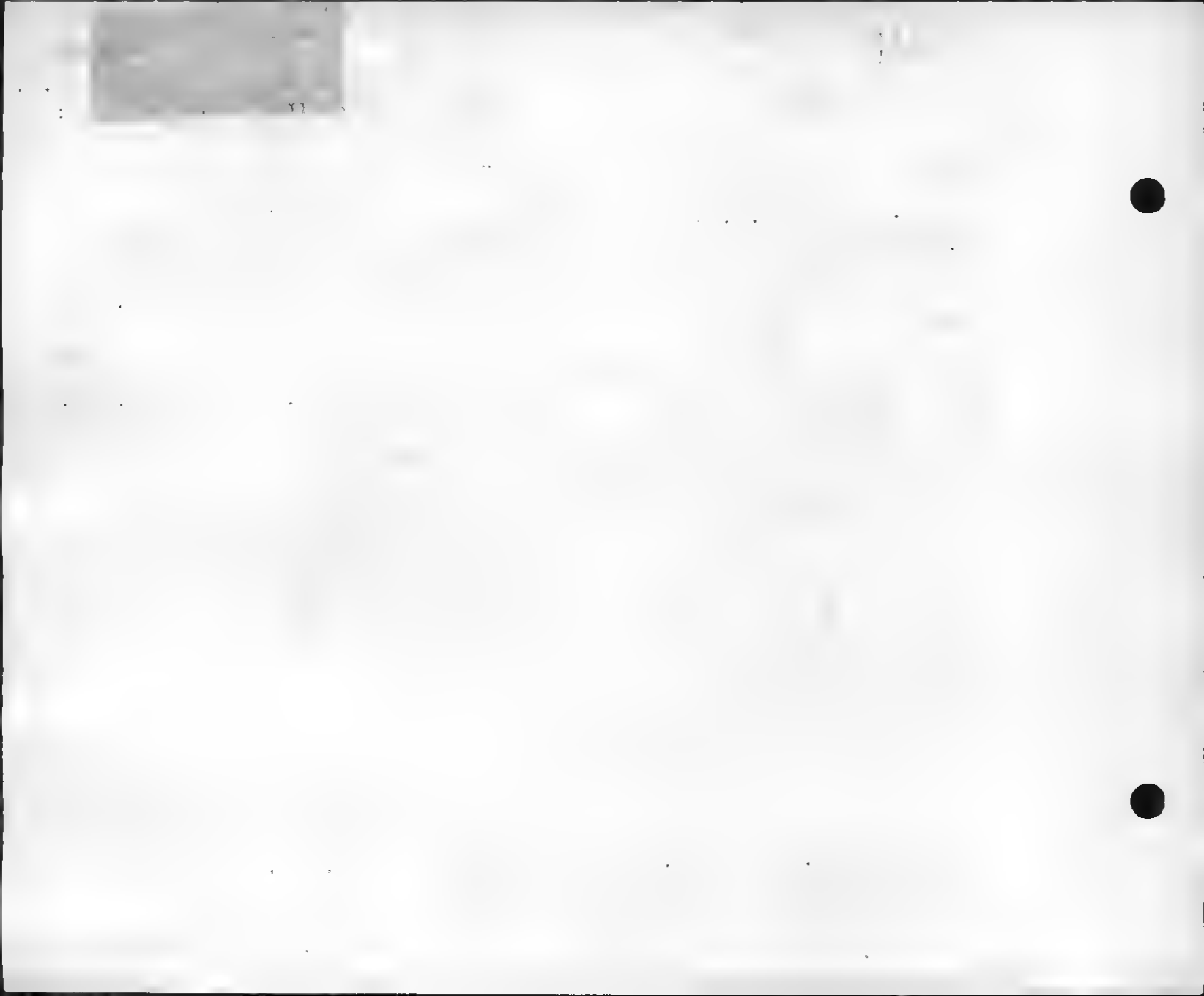
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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34985

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

1 DECEASED NAME (Type or print)		First	Middle	Last	2a DATE OF DEATH Month Day Year		2b TIME	
JOHN		W		HITE	APRIL 19 68		9:15 AM	
3 SEX	4 RACE		5 DATE OF BIRTH		6 AGE (In years last birthday)		7 IF UNDER 1 YEAR	
MALE	WHITE		7-14-98		69 YRS.		MONTHS DAYS HOURS MIN	
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH		
pa.		U.S.A.				ALLEGANY Md.		
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b KND OF BUSINESS OR INDUSTRY		
CUMBERLAND		MEMORIAL HOSPITAL		Treading Dept.		Tire		
13a USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIM.TSP		13e STREET AND NUMBER
MARYLAND		ALLEGANY		CUMBERLAND		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		439 SOUTH ST.
14 FATHER'S NAME First Middle Last			15 MOTHER'S MAIDEN NAME First Middle Last					
GEORGE HITE			JENNIE CROOKS					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)		16b. SOCIAL SECURITY NO		17 INFORMANT Address				
NO				MEMORIAL HOSPITAL, CUMBERLAND, MD.				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Severe failure - acute and chronic</i> 10X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 5870 (b) <i>Hepatitis</i> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 2 days 1 month								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>Anterior branch C.V. Disease with myocarditis</i>								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f LOCATION Street or R.F.D. No. City or Town County State				
22a I certify that (I) (this hospital) attended the deceased from <i>4/4</i> , 1968, to <i>4/19</i> , 1968, that (I) (we) last saw the deceased alive on <i>4/19</i> , 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b SIGNATURE		22c. DATE SIGNED						
<i>Thomas F. Lewis</i>		<i>4/20/68</i>						
22d. PHYSICIAN'S NAME (Type)		22e ADDRESS						
DR. THOMAS F. LEWIS		CUMBERLAND, MD.						
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)		
<i>Buried</i>		<i>Apr. 22, 1968</i>		<i>Zion Memorial Park</i>		<i>Cumberland, Allegany, Md.</i>		
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
<i>James F. Scarpelli, Cumberland, Md.</i>				<i>APR 23 1968</i>		<i>James J. Jager</i>		





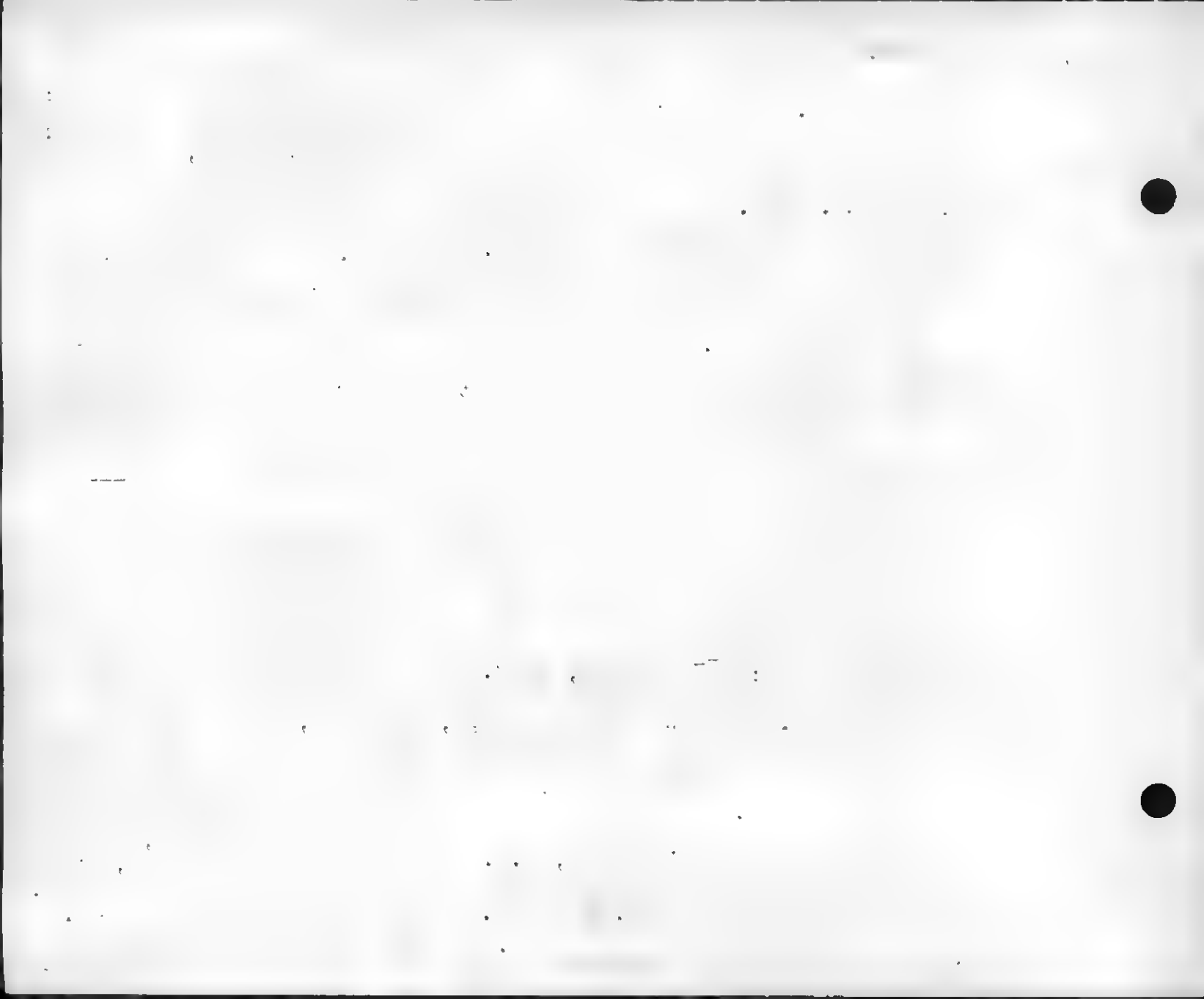
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMS. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
10M REV. 1-68

<div>34986</div> <div>MARYLAND STATE DEPARTMENT OF HEALTH</div> <div>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</div> <div>MEDICAL EXAMINER'S CERTIFICATE OF DEATH</div>													
1 DECEASED NAME (Type or Print)			First		Middle		Last		2a DATE KNOWN <input checked="" type="checkbox"/> Month Day Year		2b HOUR OF ESTI-DEATH MATED		
J. William Hunt									April 30 1968		5:20 PM		
3 SEX	4 RACE	5 DATE OF BIRTH		6 AGE (In years lost birthday)		F UNDER 1 YEAR		IF UNDER 24 HRS		2c DATE PRONOUNCED DEAD		2d HOUR	
Male	White	May 9, 1892		75 YRS		MONTHS DAYS		HOURS MIN		April 30, 1968		5:20 PM	
7a BIRTHPLACE (State or foreign country)			7b CITIZEN OF WHAT COUNTRY?			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH				
Tunnelton Wva.			USA						Allegany			MD	
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)						12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY		
Cumberland			Sacred Heart Hosp. DOA						Editor		Newspaper		
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b COUNTY			13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER			
Md			Allegany			Cumberland		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		532 Washington Street			
14 FATHER'S NAME			First		Middle		Last		15 MOTHER'S MAIDEN NAME				
James S. Hunt									Ella Cruise				
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b SOCIAL SECURITY NO			17 INFORMANT			ADDRESS				
unknown						Robert Hunt			Tunnelton West Virginia				
18 CAUSE OF DEATH (Enter on any one cause per line for (a), (b), and (c))											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)											SHOCK		SUDDEN
DUE TO, OR AS A CONSEQUENCE OF													
Conditions, if any, which gave rise to immediate cause (a), storing the underlying cause last.											MULTIPLE INJURIES AND FRACTURES		----
DUE TO OR AS A CONSEQUENCE OF (b)													
DUE TO OR AS A CONSEQUENCE OF (c)													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c)													
P16:													
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
21a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>			21b TIME OF INJURY Month, Day, Year			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
CAUSE OF DEATH			4:30 PM April 30, 1968.			Driver of car in collision							
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK			21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f LOCATION Street or R.F.D. No			City or Town		County State		
			Rt. #40 West of			La Vale, Allegany, Maryland							
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: <del>XXXXXX</del> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE			BENEDICT SKITARELIC, M.D.						CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b DATE SIGNED		
EXAMINER'S NAME (Type)									ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		APRIL 30, 1968		
									DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		CUMBERLAND, MARYLAND		
23a BURIAL, CREMATION, REMOVAL (Specify)			23b DATE		23c NAME OF CEMETERY OR CREMATORY				23d LOCATION (City or Town) (County) (State)				
Burial			May 3, 68		St. Joseph Cem.				Howesville WVa.				
24. FUNERAL DIRECTOR			ADDRESS						25a REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE		
Louis Skitarellic			Cumberland Md.						MAY 3 1968		Charles Judge		

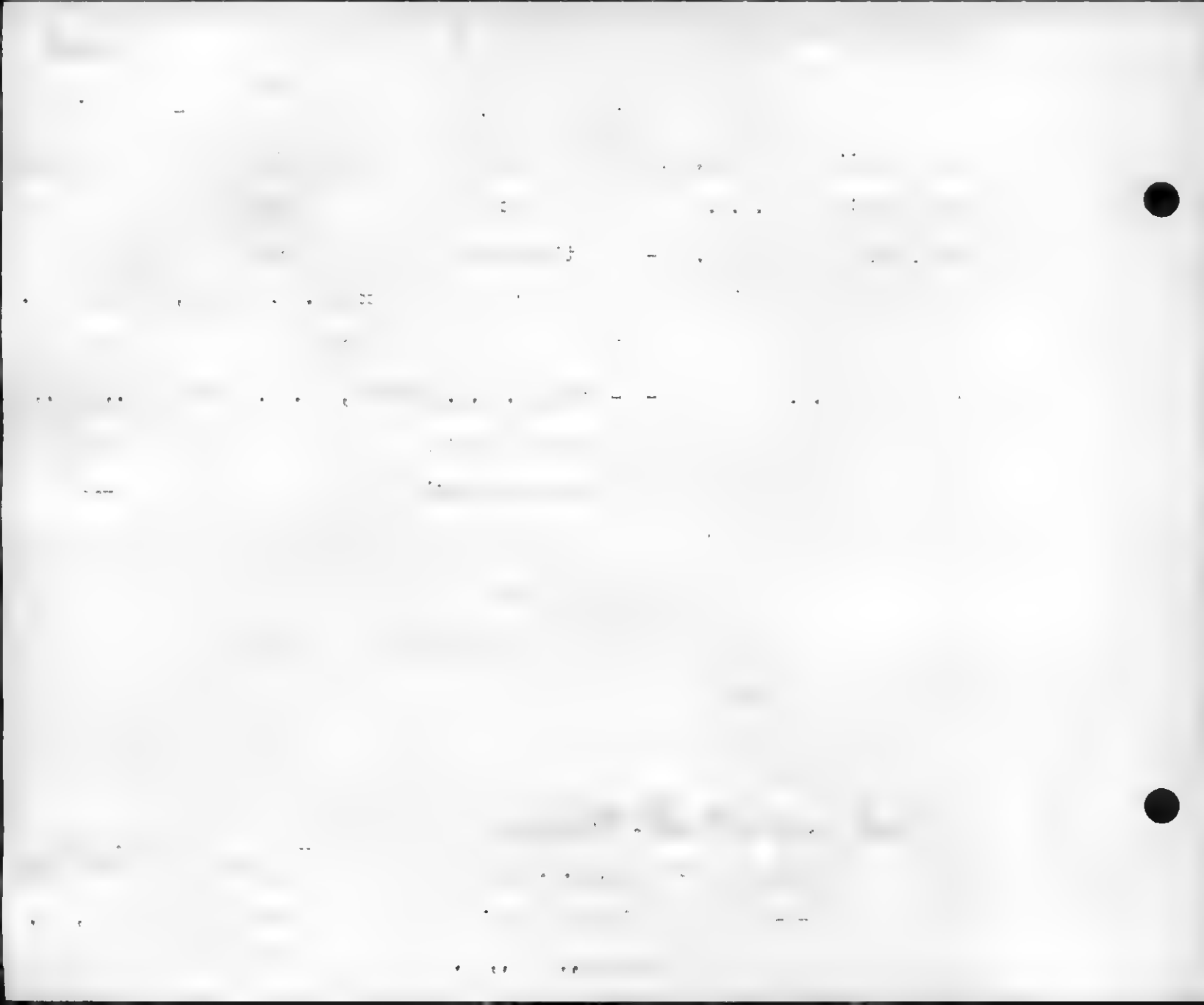


FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1 DECEASED NAME (Type or Print)			First		Middle		Last		2a DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/> 4 - 30 1968 5 a m		
Marshall			Elmer		Imes						
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (in years last birthday)	IF UNDER 1 YEAR MONTHS	IF UNDER 24 HRS DAYS	IF UNDER 24 HRS HOURS	IF UNDER 24 HRS MIN	2c DATE PRONOUNCED DEAD Month Day Year 1968 April 30 9 a m		2d HOUR	
Male	White	May 24, 1896	71 YRS								
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		Md			
Pennsylvania		U.S.A.				Allegany					
10. CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b KIND OF BUSINESS OR INDUSTRY		
Cumberland			Rt. #4 - Christie Road			Car Repairman			Railroad		
13a USAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE			13b. COUNTY		13c CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET AND NUMBER		
Maryland			Allegany		Cumberland		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		Rt. #4, Box 425, Christie Rd.		
14. FATHER'S NAME			First		Middle		Last		15. MOTHER'S MAIDEN NAME		
Upton							Imes		Louisa Johnson		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b SOCIAL SECURITY NO		17 INFORMANT		ADDRESS				
Yes			W.W. I		214-05-4199		Mrs. R.E. Streett, Rt. #4, Christie Rd., Cumb., Md				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY:										Sudden	
IMMEDIATE CAUSE (a) Coronary Occlusion											
DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary Sclerosis											
DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(c)											
19a DATE OF OPERATION				19b CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19				21c HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18)			
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <i>Benedict Skitarelic</i>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22b DATE SIGNED			
EXAMINER'S NAME (Type) Benedict Skitarelic, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				April 30, 1968			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				ADDRESS (Street, city, town or county) Cumberland, Maryland			
23a BURIAL, CREMATION, REMOVAL (Specify)			23b DATE		23c NAME OF CEMETERY OR CREMATORY			23d LOCATION (City or Town) (County) (State)			
Burial			5-2-68		Hillcrest Burial Park			Near Cumberland, Allegany, Md.			
24 FUNERAL DIRECTOR <i>Charles E. Hafer</i>						ADDRESS		25a REC'D BY REG STRAR		25b. REG. STRAR'S SIGNATURE	
Charles E. Hafer, 230 Baltimore Ave., Cumb., Md.								MAY 2 1968		<i>Charles E. Judge</i>	



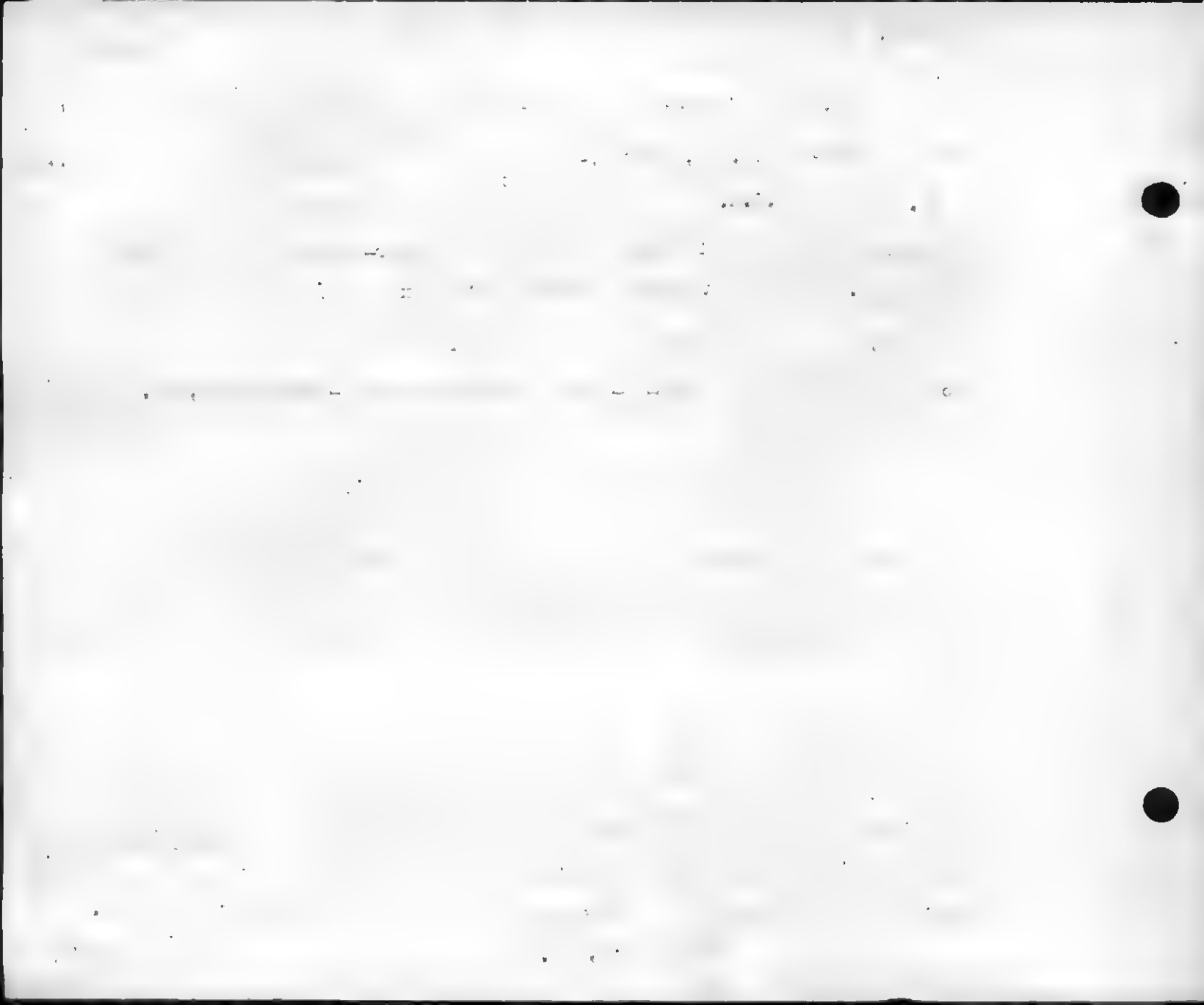
# FOR STATE HEALTH DEPT

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MEDICAL CERTIFICATION

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VR A15 (4)  
30M REV 1/68

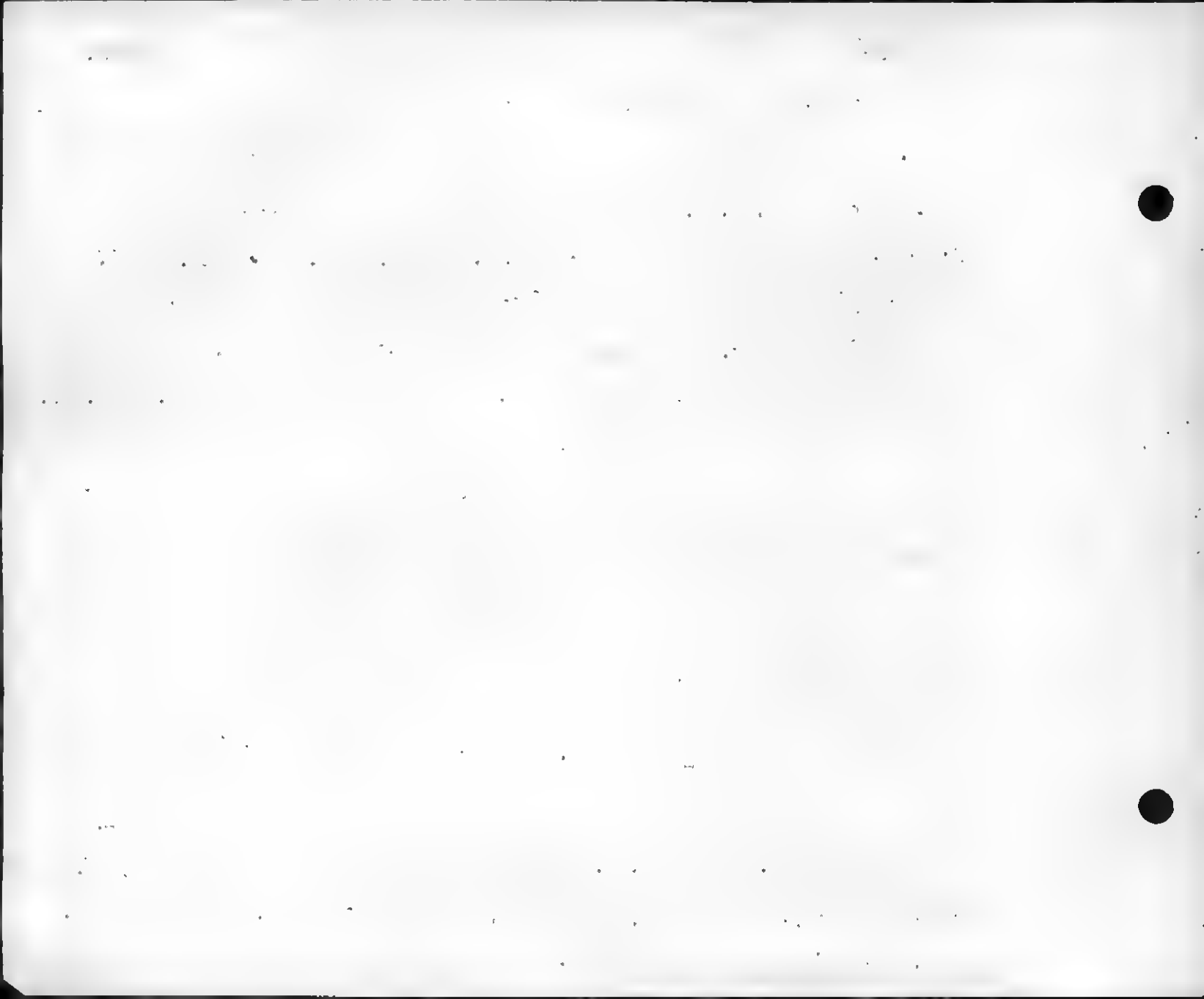
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

02088

04930

1. DECEASED-NAME (Type or print) First Middle Last Thomas Leonard Keech			2a. DATE OF DEATH April Month 16, Day 68 Year			2b. HOUR 1 A M				
3. SEX Male		4. RACE White		5. DATE OF BIRTH June 29, 1903		6. AGE (In years last birthday) 64 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN		
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Allegany Md.				
10. CITY OR TOWN OF DEATH Cumberland,			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 919 Kent Ave.			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Ret. Exec. Vice Pres.			12b. KIND OF BUSINESS OR INDUSTRY Banking	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland			13b. COUNTY Allegany		13c. CITY OR TOWN Cumberland,		13d. INS OF CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 919 Kent Ave.	
14. FATHER'S NAME First Middle Last William E. Keech			15. MOTHER'S MAIDEN NAME First Middle Last Mary A. O'Neil							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)			16b. SOCIAL SECURITY NO 214-05-6791		17. INFORMANT Address Mrs. Hazel M. Keech 919 Kent Ave. Cumb. Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 4109 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) Coronary Heart Disease DUE TO, OR AS A CONSEQUENCE OF (c) 9 years APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 day										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from 12 6, 19 60 to 4 - 16 19 68, that (I) (we) lost saw the deceased alive on 4 - 8 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE Ralph W. Ballin					DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED 4-17-68		
22d. PHYSICIAN'S NAME (Type) Ralph W. Ballin, M. D.					22e. ADDRESS 62 Greene St. Cumberland, Md. 21502					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 4/19/68		23c. NAME OF CEMETERY OR CREMATORY St. Mary's Burial Park			23d. LOCATION (City or Town) (County) (State) Cumberland, Allegany Md.			
24. FUNERAL DIRECTOR H. Wayne George Cumberland, Md.					25a. REC'D BY REGISTRAR DATE APR 22 1968		25b. REGISTRAR'S SIGNATURE J. Charles Judge			

MEDICAL CERTIFICATION





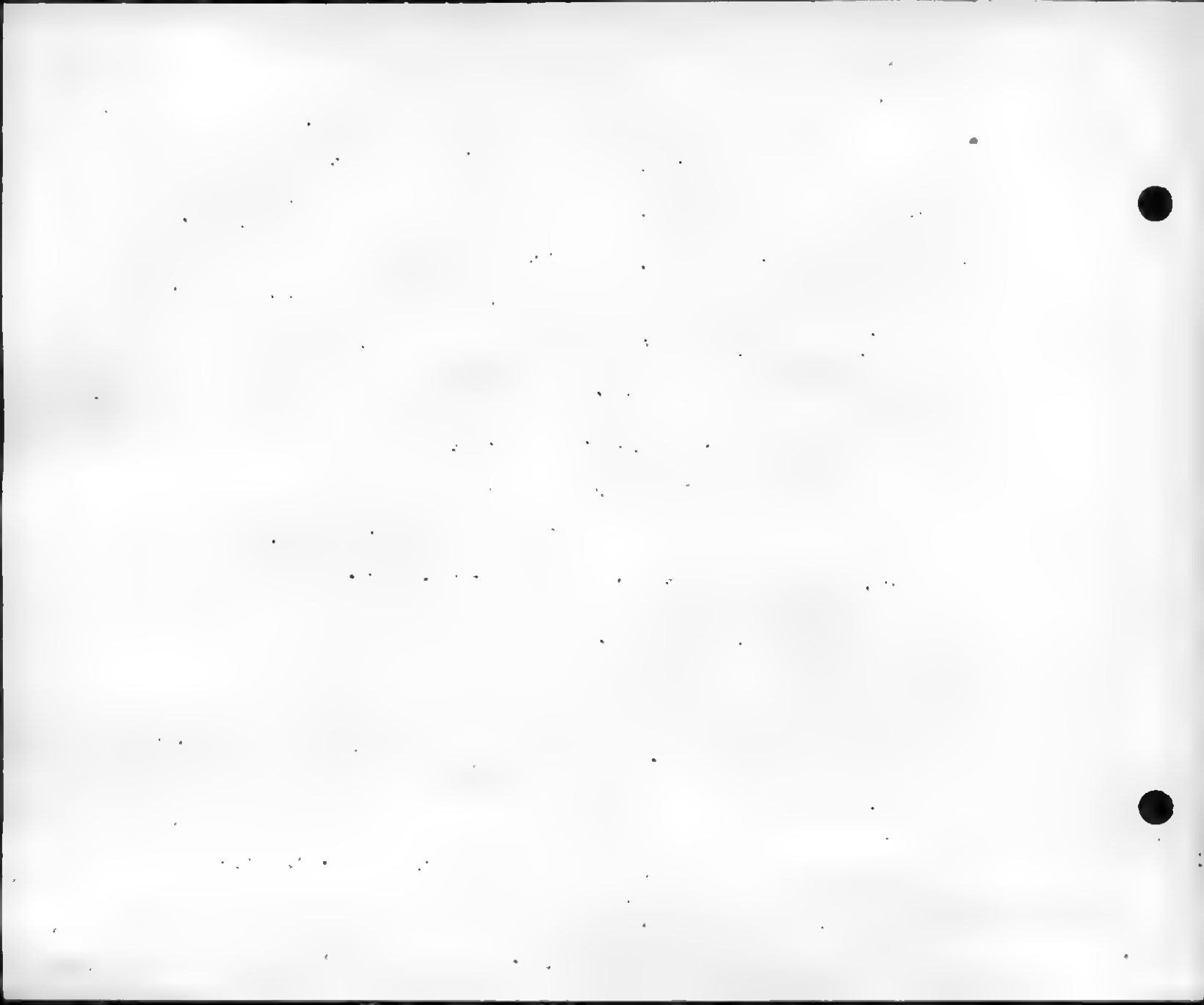
TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2) should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV 1/68

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) First Middle Last Marie C Kelly			2a. DATE OF DEATH Month Day Year April 17 1968			2b. HOUR MIN. 8:45 M	
3. SEX Female		4. RACE White		5. DATE OF BIRTH 4-11-1894		6. AGE (In years last birthday) YRS. MONTHS DAYS 73	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Allegany Md	
10. CITY OR TOWN OF DEATH Cumberland, Md		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Cumberland Nursing Center		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE md		13b. COUNTY Allegany		13c. CITY OR TOWN Cumberland		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME First Middle Last William E. MALONE		15. MOTHER'S MAIDEN NAME First Middle Last MARGARET - NOONAN		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) No			
16a. SOCIAL SECURITY NO None		17. INFORMANT Address CATHERINE LAUSCHER, Calif.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) HEPATO-RENAL FAILURE 159.8 DUE TO, OR AS A CONSEQUENCE OF (b) HEPATIC METASTASIS DUE TO, OR AS A CONSEQUENCE OF (c) CARCINOMA OF COLON AND OVARY 13 MONTHS							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) PULMONARY AND OSSEOUS METASTASIS							
19a. DATE OF OPERATION MARCH 1967		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Abdominal CARCINOMATOSIS		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from OCT, 1967, to APRIL 17, 1968, that (I) (we) last saw the deceased alive on APRIL 4, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Richard E. Schindler MD				22c. DATE SIGNED April 17-1968		22d. PHYSICIAN'S NAME (Type) Dr. Richard E. Schindler MD	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Apr. 20, 1968		23c. NAME OF CEMETERY OR CREMATORY St. Peter & Paul Cemetery		23d. LOCATION (City or Town) (County) (State) Cumberland Allegany, Md.	
24. FUNERAL DIRECTOR James F. Scarpelli, Cumberland, Md.				25a. REC'D BY REGISTRAR DATE APR 18 1968		25b. REGISTRAR'S SIGNATURE J. Charles Judge	



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

1 DECEASED-NAME (Type or print) <b>JAMES NMI KENNEDY</b>			2a DATE OF DEATH 4 Month 26 Day 68 Year			2b. HOJR 3:55 PM				
3 SEX <b>MALE</b>		4 RACE <b>WHITE</b>		5 DATE OF BIRTH <b>1-14-03</b>		6 AGE (In years last birthday) <b>65</b> YRS		F UNDER 1 YEAR MONTHS DAYS		
7a BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>ALLEGANY</b> Md.				
10. CITY OR TOWN OF DEATH <b>CUMBERLAND</b>			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>SACRED HEART HOSPITAL</b>			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>RAILROAD</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>RAILROAD</b>	
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MD.</b>			13b COUNTY <b>ALLEGANY</b>		13c CITY OR TOWN <b>CUMBERLAND</b>		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER <b>633 N. CENTRE STREET</b>	
14 FATHER'S NAME First Middle Last <b>JAMES KENNEDY</b>				15. MOTHER'S MAIDEN NAME First Middle Last <b>CLARA CREEK KENNEDY</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or, not known <input type="checkbox"/> (If yes give war or dates of service)			16b SOCIAL SECURITY NO <b>721 16 9528</b>		17 INFORMANT <b>900 GLETON DRIVE SACRED HEART HOSPITAL CUMBERLAND, MD. 21502</b>					
18 CAUSE OF DEATH (Enter on only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Angina pectoris</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>myocardial infarction</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>hypertension</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>7 days</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No.		City or Town		State
22a. I certify that (I) (this hospital) attended the deceased from <b>July 5, 1965</b> , to <b>April 26, 1968</b> , that (I) (we) lost saw the deceased alive on <b>April 26, 1968</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>DR. BLANE M. SCHINDLER</b>						DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>4/27/68</b>		
22d. PHYSICIAN'S NAME (Type) <b>DR. BLANE M. SCHINDLER</b>						22e ADDRESS <b>43 GREENE STREET CUMBERLAND, MARYLAND 21502</b>				
23a. BURIAL, CREMATION REMOVAL (Specify)			23b DATE <b>Apr. 29, 1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>B.V. Christian Church Co.</b>			23d LOCATION (City or Town) (County) (State) <b>Buck Valley, Pa.</b>		
24. FUNERAL DIRECTOR <b>James F. Scarpelli, Cumberland, Md.</b>						25a REC'D BY REGISTRAR DATE <b>APR 30 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

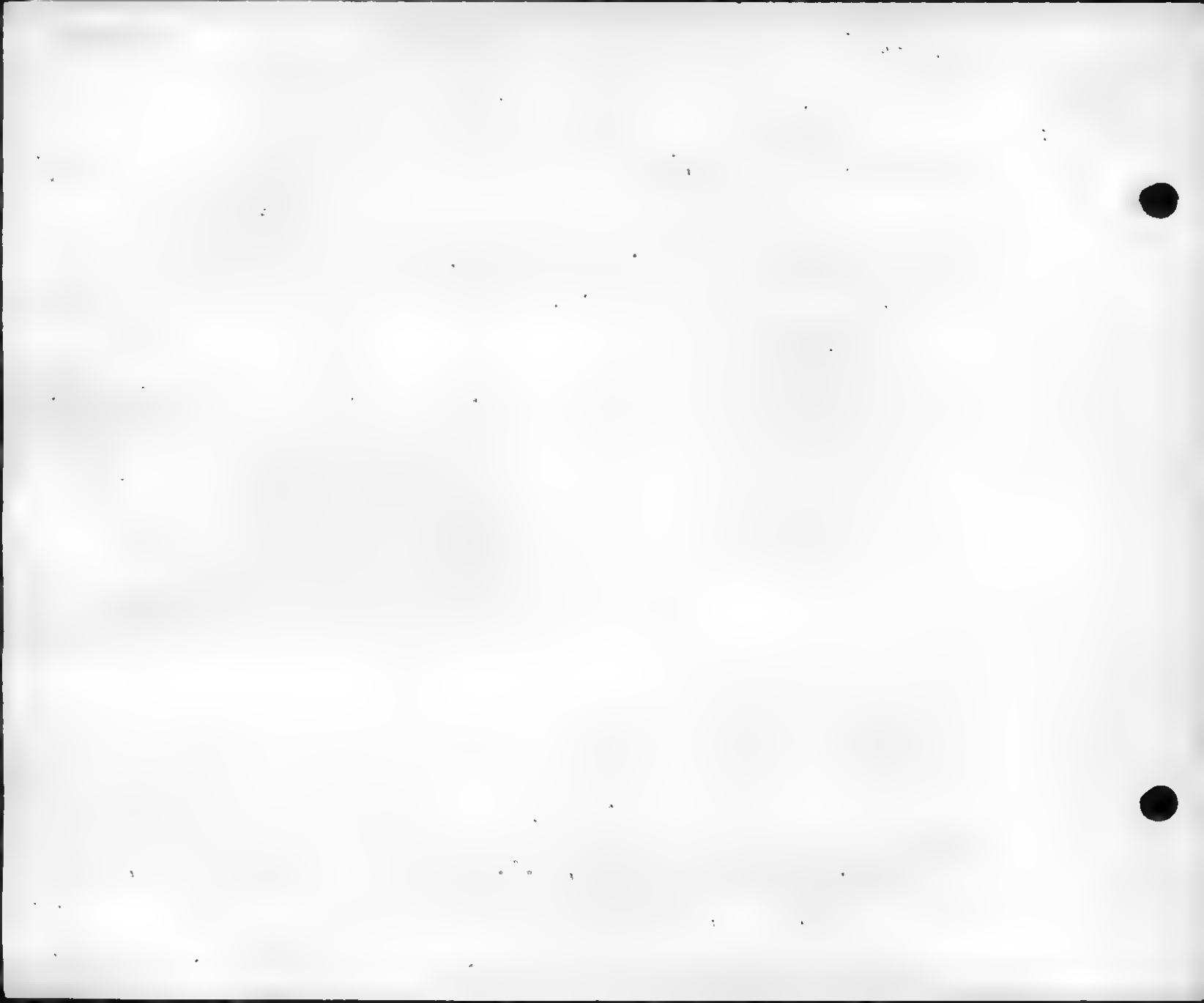
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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMS-1. 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or Print)			First M.dle Last			2a. DATE KNOWN OF ESTI- DEATH MATED			2b. HOUR		
JAMES O. KERNS						Month Day Year			1968 10A		
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (in years last birthday)	F UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN		2c. DATE PRONOUNCED DEAD			2d. HOUR
MALE	WHITE	JULY 13, 1887	80 YRS					Month Day Year			10A
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH		
W. VA.			USA						ALLEGANY Md		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY		
CUMBERLAND			DOA MEMORIAL HOSP			CARPENTER			RAILROAD		
13a. USUAL RESIDENCE (Where deceased admitted on)			13b. CITY OR TOWN			13c. INSIDE CITY LIMITS?			13d. STREET AND NUMBER		
STATE			COUNTY			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			616 N. MECHANIC STREET		
14 FATHER'S NAME			15 MOTHER'S MAIDEN NAME								
First Middle Last			First Middle Last								
JACOB KERNS			MAGGIE AMICK								
16a. WAS DECEASED EVER (Yes, no, or unknown)			16b. SOCIAL SECURITY NO			17. INFORMANT			ADDRESS		
NO			705 12 4647			MRS. ADA KERNS			CUMBERLAND, MD.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)										coronary occlusion	
410.9 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last										coronary sclerosis	
(b)										--	
(c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
410.											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY?		
									YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M.			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
			19								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION: Street or R.F.D. No			City or Town County State		
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE			Benedict Skitarellic M.D.						CHIEF MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type)			BENEDICT SKITARELIC, M.D.						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
									DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
									ADDRESS (Street, city, town, or county) CUMBERLAND, MARYLAND		
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)		
BURIAL			APRIL 21, 1968			ROSE HILL CEMETERY			CUMBERLAND MARYLAND		
24. FUNERAL DIRECTOR			ADDRESS			25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE		
BYRON KIGHT			CUMBERLAND, MD.			DATE APR 22 1968			Charles Judge		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours of death.

VR A15 (4)  
30M REV 1-68

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print) <b>EDWARD</b>			First <b>W.</b> Middle <b>KNABE</b> Last			2a. DATE OF DEATH <b>4</b> Month <b>13</b> Day <b>68</b> Year		2b. HOUR <b>1:45 PM</b>	
3. SEX <b>MALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH <b>10-6-1904</b>		6. AGE (In years lost birthday) <b>63</b> YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) <b>WISC.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>ALLEGANY</b> Md.			
10. CITY OR TOWN OF DEATH <b>CUMBERLAND</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>MEMORIAL HOSP.</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Retired Postal Employee</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if admission) STATE <b>MARYLAND</b>			13b. COUNTY <b>ALLEGANY</b>		13c. CITY OR TOWN <b>CUMBERLAND</b> <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET AND NUMBER <b>508 TALBOT STREET</b>		
14. FATHER'S NAME <b>EMIL</b>			First <b>KNABE</b> Middle Last			15. MOTHER'S MAIDEN NAME First <b>BERTHA</b> Middle Last <b>KNAACK</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. <b>456-54-2607</b>		17. INFORMANT Address <b>MEMORIAL HOSPITAL - CUMBERLAND, MD.</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary fibrous lesion</b> <b>1107</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Myocardial infarction</b> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>metab</b> <b>5 days</b>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>DR. V. P. DROSS</b>		DEGREE <b>M.D.</b> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>April 14, 1968</b>					
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS <b>456 N. CENTRE ST., CUMBERLAND, MD</b>							
23a. BURIAL CREMATION, REMOVAL (Specify)		23b. DATE <b>4/18/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>WILDWOOD CEMETERY</b>		23d. LOCATION (City or Town) (County) (State) <b>SHEBOYGAN SHEBOYGAN WISCONSIN</b>			
24. FUNERAL DIRECTOR <b>H. LEE SILCOX 404 DECATUR STREET CUMBERLAND MARYLAND</b>				ADDRESS		25a. REC'D BY REGISTRAR <b>DATE APR 17 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



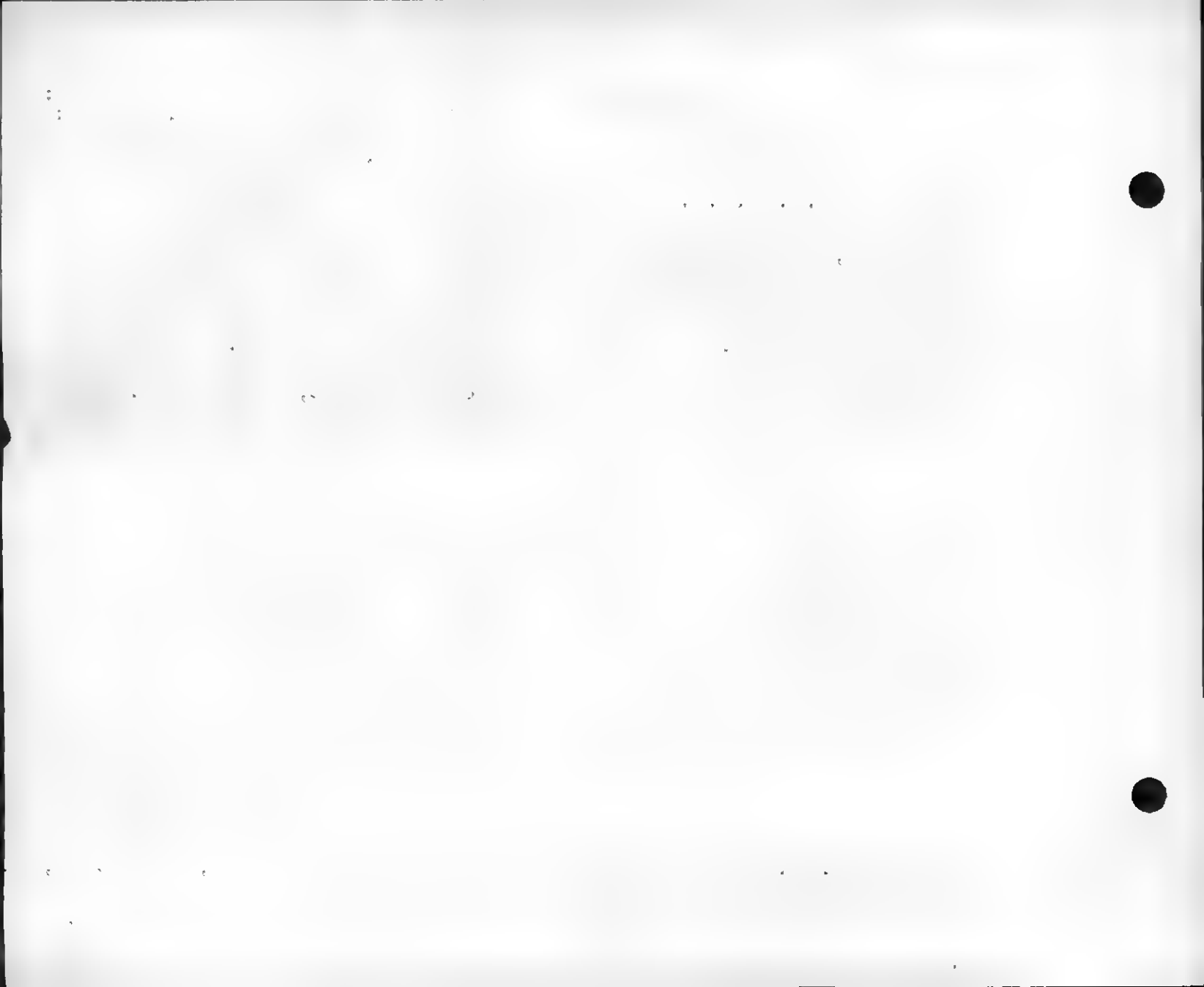


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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
**CERTIFICATE OF DEATH**

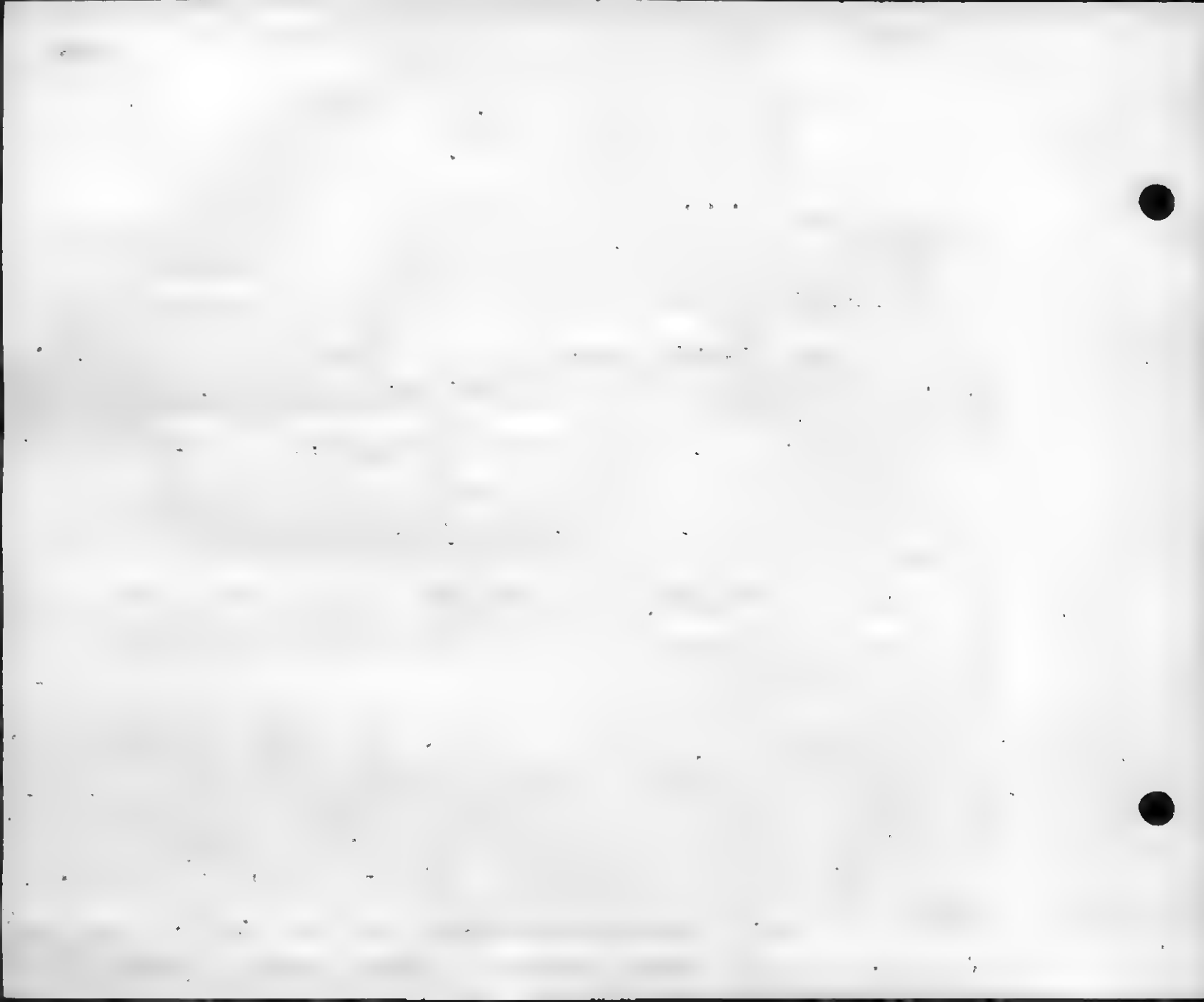
1. DECEASED-NAME (Type or print) <b>MINNIE MARGUERITE KOLB</b>		2a. DATE OF DEATH Month <b>APRIL</b> Day <b>27</b> Year <b>1968</b>		2b. HOUR <b>3:10 PM</b>
3 SEX <b>FEMALE</b>	4 RACE <b>WHITE</b>	5. DATE OF BIRTH <b>FEBRUARY 2, 1891</b>		6 AGE (In years last birthday) <b>77</b> YRS.
7a. BIRTHPLACE (State or foreign country) <b>WASHINGTON, D.C. U.S.A.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
9. COUNTY OF DEATH <b>ALLEGANY</b>		Md.		
10. CITY OR TOWN OF DEATH <b>CUMBERLAND, MD.</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>MEMORIAL HOSPITAL</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>housewife</b>
12b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>				
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <b>MARYLAND</b>		13b. COUNTY <b>ALLEGANY</b>	13c. CITY OR TOWN <b>CUMBERLAND</b>	13d. INSIDE CITY LIM 157 <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
13e. STREET AND NUMBER <b>906 BEDFORD STREET</b>				
14. FATHER'S NAME First Middle Last <b>GEORGE W. SHAE</b>		15. MOTHER'S MAIDEN NAME First Middle Last <b>LOTTIE L. LIPPOLD</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16b. SOCIAL SECURITY NO <b>215-36-639D</b>		17 INFORMANT <b>MEMORIAL HOSPITAL, CUMBERLAND, MARYLAND</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Congestive heart failure</b> <b>412.7</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause (a) (b) <b>ASHD, EIT</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Pulmonary microembolization</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b> <b>2 months</b> <b>1 month</b>
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Diabetes mellitus</b>				
19a. DATE OF OPERATION <b>7-1-66</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Diabetes mellitus</b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.				
22b. SIGNATURE <b>V. P. Dross</b>		DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>4-29-68</b>
22d. PHYSICIAN'S NAME (Type) <b>DR. V. P. DROSS</b>		22e. ADDRESS <b>1909 FREDERICK ST., CUMBERLAND, MD.</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>4-29-68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Hillcrest Burial Park</b>
23d. LOCATION (City or Town) (County) (State) <b>Cumberland Allegany Md.</b>				
24. FUNERAL DIRECTOR <b>H. Lee Silcox</b>		ADDRESS <b>4041 Decatur St. Cumb., Md.</b>		25a. REC'D BY REGISTRAR <b>DATE APR 30 1968</b>
25b. REGISTRAR'S SIGNATURE <b>Charles Juize</b>				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print)			First James		Middle Layman		Last Layman		2a. DATE OF DEATH Month 4 Day 1968		
3. SEX Male			4. RACE White		5. DATE OF BIRTH Aug. 6, 1899		6. AGE (In years last birthday) 68 YRS.		2b. HOUR 7:15 AM		
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Allegany Md.				
10. CITY OR TOWN OF DEATH Cumberland			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Sylvan Retreat			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) STATE Maryland			13b. COUNTY Allegany		13c. CITY OR TOWN Frostburg		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 376 Welsh Hill		
14. FATHER'S NAME First Middle Last Daniel Burhman Layman			15. MOTHER'S MAIDEN NAME First Middle Last Mary McAlpine								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown None			16b. SOCIAL SECURITY NO. none		17. INFORMANT Evan Layman, Frostburg, Md.			Address 21532			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute coronary thrombosis</u>										<u>a few minutes</u>	
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerosis</u>										<u>many years</u>	
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Chronic A.C.V.D. with Hypertension</u>										<u>many years</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Latent Syphilis - Ch. Prostatitis</u>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE, BUILDING, ETC.			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <u>April 15, 1967</u> , to <u>April 4, 1968</u> , that (I) (we) last saw the deceased alive on <u>April 3, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>John A. Tepper, MD</u>						DEGREE ATTENDING PHYS.		MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <u>4-5-68</u>	
22d. PHYSICIAN'S NAME (Type) <u>John A. Tepper</u>						22e. ADDRESS <u>Memorial Hospital, Cumberland, Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			23b. DATE <u>4-6-68</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Fbg. Memorial Park</u>			23d. LOCATION (City or Town) (County) (State) <u>Frostburg, Md.</u>			
24. FUNERAL DIRECTOR <u>Joseph R. Durst, Frostburg, Md. 21532</u>						25a. REC'D BY REGISTRAR DATE <u>APR 9, 1968</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			



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6-596  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
**CERTIFICATE OF DEATH**

1 DECEASED-NAME (Type or print) <b>JANE</b>		First <b>N.</b> Middle <b>LAYMAN</b> Last		2a. DATE OF DEATH Month <b>4</b> Day <b>7</b> Year <b>68</b>		2b. HOUR <b>7:30AM</b>	
3 SEX <b>FEMALE</b>		4 RACE <b>WHITE</b>		5. DATE OF BIRTH <b>9-2-92</b>		6 AGE (In years last birthday) <b>75</b> YRS.	
7a. BIRTHPLACE (State or foreign country) <b>W. VIRGINIA</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH <b>ALLEGANY</b> Md	
10. CITY OR TOWN OF DEATH <b>CUMBERLAND</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>MEMORIAL HOSPITAL</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>	
13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE <b>MARYLAND</b>		13b. COUNTY <b>ALLEGANY</b>		13c. CITY OR TOWN <b>CUMBERLAND</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET AND NUMBER <b>397 MC MULLEN HIGHWAY</b>		14 FATHER'S NAME First <b>WILLIAM</b> Middle <b>NAISMATH</b> Last		15. MOTHER'S M.A.D.E.N. NAME First <b>ELLEN</b> Middle <b>WALKER</b> Last			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <b>NO</b> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT <b>MEMORIAL HOSPITAL</b>		Address <b>CUMBERLAND, MD.</b>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Uterine Sclerotic Cardiovascularis</b> <b>H127</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>4-7-68</b>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, not by medical examiner)		21b. TIME OF INJURY HOUR A.M. _____ Month _____ Day _____ Year <b>19</b> P.M. _____		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No _____ City or Town _____ County _____ State _____			
22a. I certify that (I) (this hospital) attended the deceased from <b>11-25-1967</b> to <b>4-7-1968</b> , that (I) <del>(we)</del> last saw the deceased alive on <b>4-6-1968</b> , and that in (my) <del>(our)</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>(we)</del> <del>(did)</del> (did not) view the body after death.							
22b. SIGNATURE <b>W. F. Williams</b>		DEGREE <b>DR. W. F. WILLIAMS</b>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>4-8-68</b>	
22d. PHYSICIAN'S NAME (Type) <b>DR. W. F. WILLIAMS</b>		22e. ADDRESS <b>CUMBERLAND, MD.</b>					
23a. BURIAL, CREMATION REMOVAL (Specify) <b>BURIAL</b>		23b. DATE <b>APRIL 10, 1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>FROSTBURG MEMORIAL PARK</b>		23d. LOCATION (City or Town) (County) (State) <b>FROSTBURG ALLEGANY MD.</b>	
24. FUNERAL DIRECTOR <b>BYRON KIGHT</b>		ADDRESS <b>CUMBERLAND, MD.</b>		25a. REC'D BY REGISTRAR <b>APR 11 1968</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>	



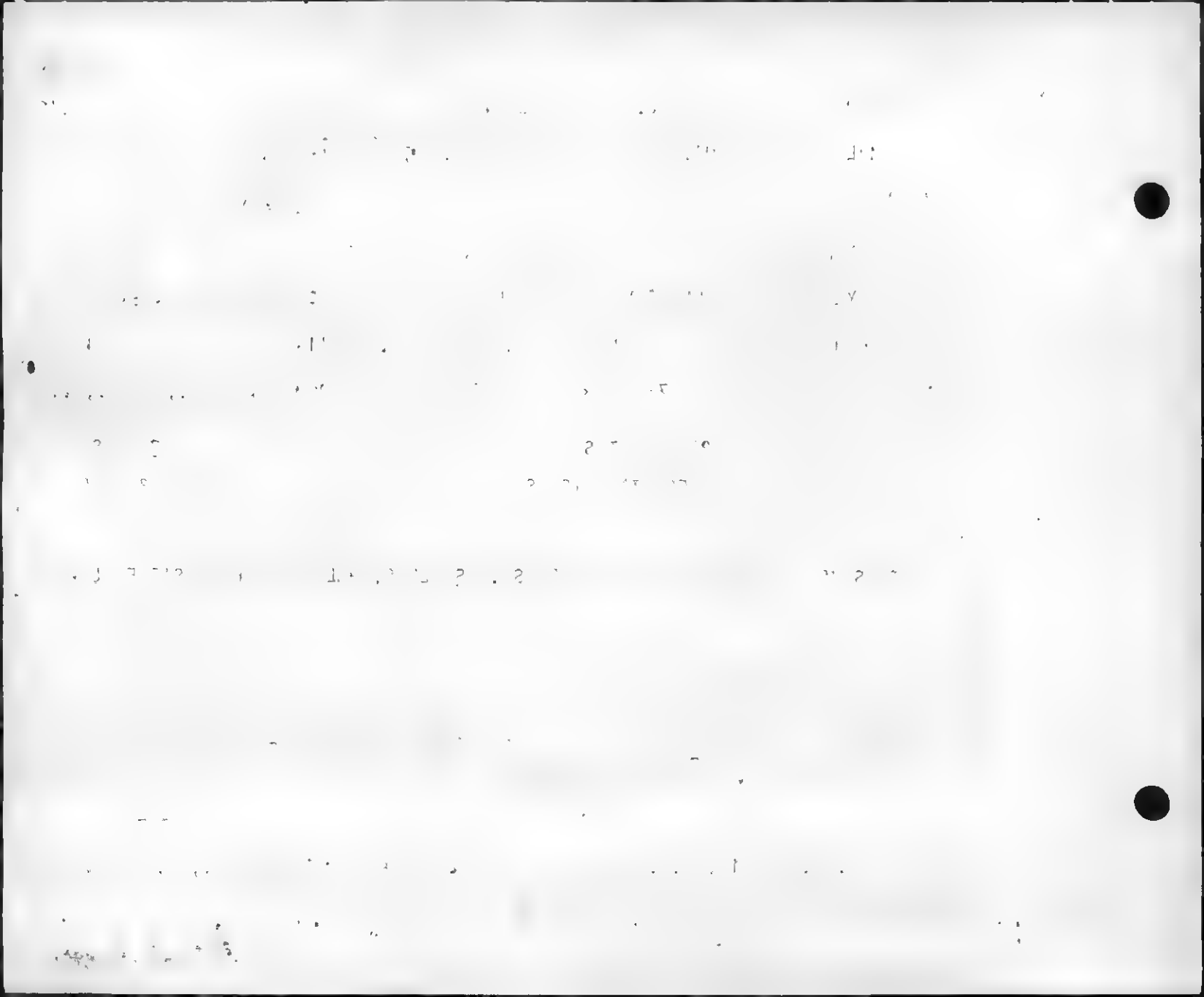
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VR A15  
304 REV 1-69

MD99.  
MAYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

1 DECEASED NAME (Type or print) <b>JOHN</b>		First <b>J.</b>		Middle <b>LEWIS</b>		Last		2a. DATE OF DEATH 04 Month Day 08 Year 88		2b. HOUR 8:10 P.M.		
3 SEX <b>MALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH <b>Jan. 21, 1906</b>		6. AGE (in years) <b>82</b> YRS		7 UNDER 1 YEAR MONTHS DAYS		8 UNDER 24 HRS. HOURS MIN		
7a. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9 COUNTY OF DEATH <b>ALLEGANY COUNTY</b> Md						
10 CITY OR TOWN OF DEATH <b>CUMBERLAND</b>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>SACRED HEART HOS.</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>BAR TENDER</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>TAVERN</b>						
13a. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) STATE <b>MARYLAND</b>		13b. COUNTY <b>ALLEGANY</b>		13c. CITY OR TOWN <b>CUMBERLAND</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>205 BALTIMORE AVENUE</b>				
14. FATHER'S NAME First <b>JOSHUA</b> Middle <b>LEWIS</b> Last <b>WOLF</b>				15. MOTHER'S MAIDEN NAME First <b>CATHERINE</b> Middle <b>LEWIS</b> Last <b>LEWIS</b>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, <input type="checkbox"/> No, <input checked="" type="checkbox"/> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO <b>217-10-5784</b>		17 INFORMANT <b>HOSPITAL RECORD, 900 SETON DR., CUMB., MD.</b>		Address <b>21502</b>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>PERITONITIS</b> DUE TO, OR AS A CONSEQUENCE OF <b>PERFORATED VISCUS</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 DAYS</b> <b>3 DAYS</b>												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>HYPERTENSIVE AND CORONARY HEART DISEASE. CNS. LUES. PULMONARY FIBROSIS FOLLOWING TB</b>												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State								
22a. I certify that (I) (this hospital) attended the deceased from <b>9 - 10</b> , 19 <b>67</b> , to <b>4 - 8</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>19 68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <b>Regis. Ballin M.D.</b> DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>								22c. DATE SIGNED <b>4-9-68</b>				
22d. PHYSICIAN'S NAME (Type) <b>R. W. BALLIN, M.D.</b>				22e. ADDRESS <b>62 GREENE STREET, CUMB., MD. 21502</b>								
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>Apr. 11, 1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Hillcrest Burial Park</b>		23d. LOCATION (City or Town) (County) (State) <b>Cumberland, Allegany, Md.</b>						
24 FUNERAL DIRECTOR <b>James F. Scarpelli, Cumberland, Md.</b>				25a. RECD BY REGISTRAR DATE <b>APR 16 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>						



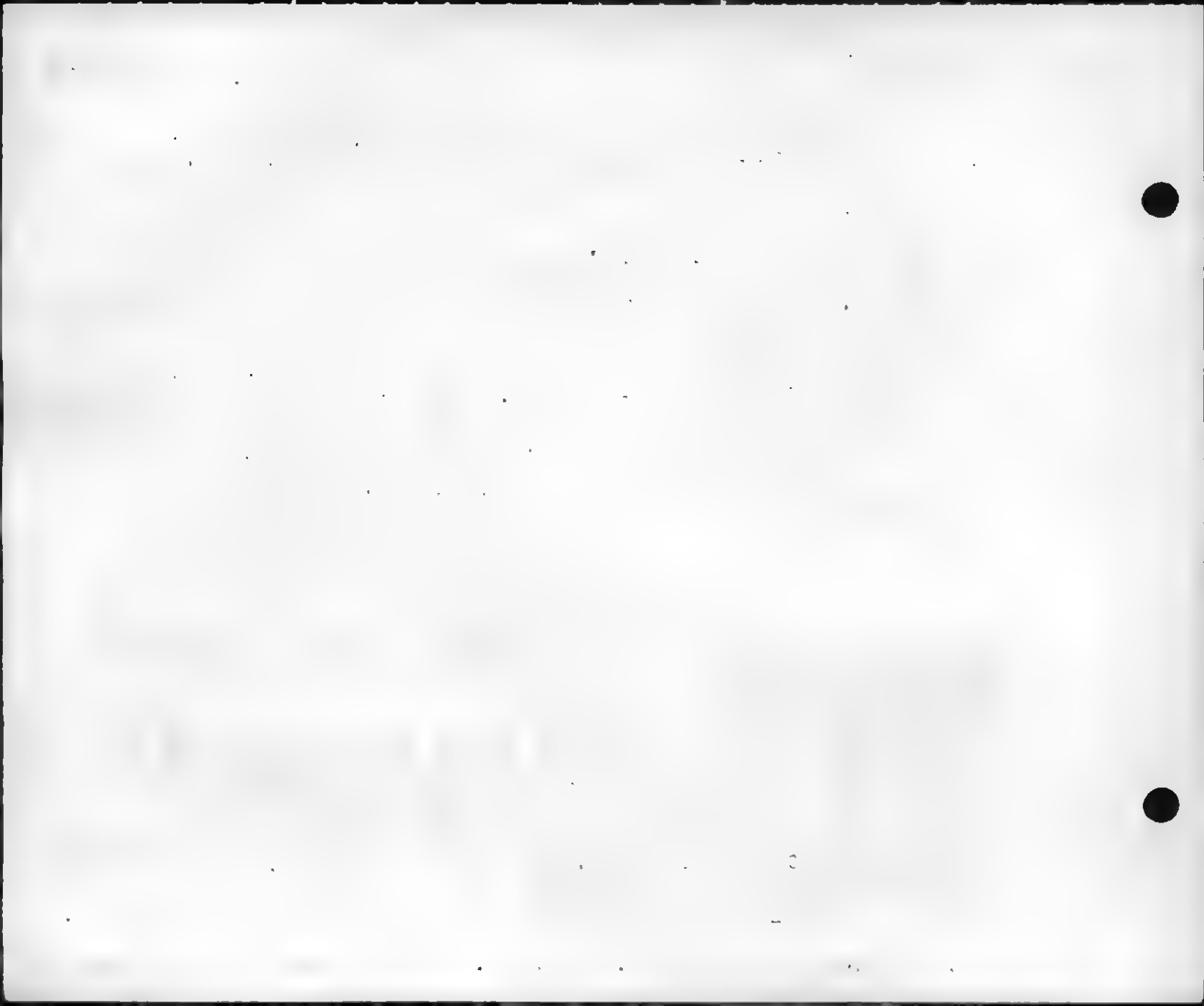


FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 2, 3 and 4 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF DEATH			2b. HOUR		
Darrel Eugene Livengood						APRIL 9, 1968			1:25 AM		
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (in years last birthday)	IF UNDER 1 YEAR MONTHS DAYS		F. UNDER 24 HRS HOURS MIN		2c. DATE PRONOUNCED DEAD			2d. HOUR
Male	White	7-4-1919	48 YRS					APRIL 9, 1968			1:25 AM
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. COUNTY OF DEATH			12b. KIND OF BUSINESS OR INDUSTRY		
Salisbury, Pa.		USA				Allegany Md					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY		
Cumberland			SACRED HEART HOSPITAL			Laborer			Colanese		
13a. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN		3d. INSIDE CITY, TOWN?		13e. STREET AND NUMBER	
Md.			Allegany			LaVale		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		541 North First Street	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			17. INFORMANT			117 MONEY Avenue		
Harrison Livengood			Ruth Jones			Mrs. Dorothy Smith			LaVale, Maryland		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO			17. INFORMANT			117 MONEY Avenue		
Yes			217-10-6124			Mrs. Dorothy Smith			LaVale, Maryland		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) SHOCK										5 HOURS	
DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										6 Hours	
(b) HEMORRHAGE, MULTIPLE FRACTURES											
DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?			
								YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>			21b. TIME OF INJURY Month, Day Year			21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)					
CAUSE OF DEATH			7:30 PM 4 - 9 1968			truck by auto					
21a. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK			21b. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No			City or Town		
						LaVale			Allegany Md		
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE			BENEDICT SKITARELIC, M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED		
						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			APRIL 9, 1968		
EXAMINER'S NAME (Type)						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			ADDRESS (Street, city, town, or county)		
						CUMBERLAND, MARYLAND					
23a. BURIAL CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town)			(County) (State)	
Burial		4-11-68		Hillcrest Cemetery			Cumberland			Allegany Md.	
24. FUNERAL DIRECTOR				ADDRESS				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
H. Lee Silcox				404 Decatur St., Cumb., Md.				APR 11 1968		Charles Judge	



**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

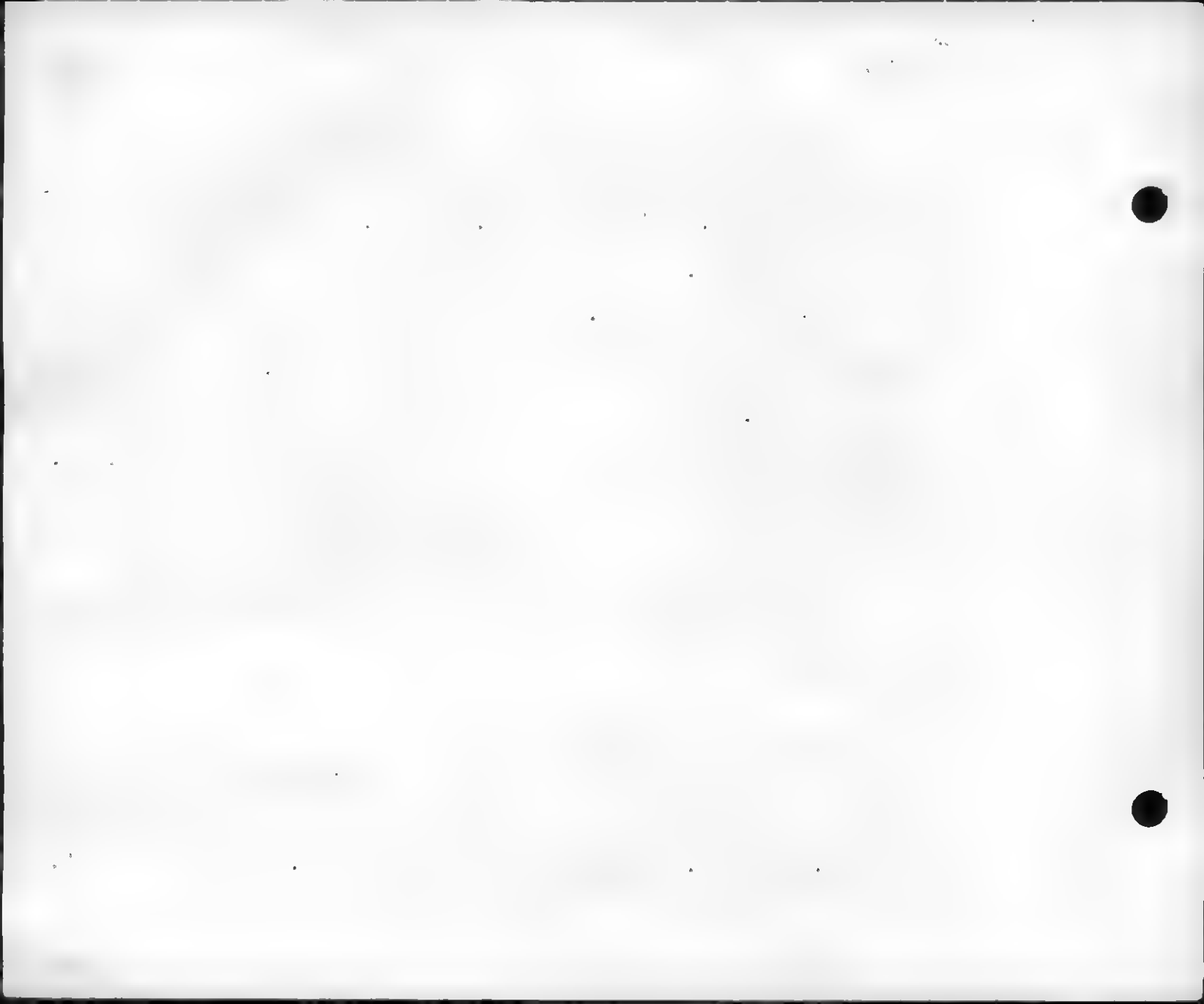
**CERTIFICATE OF DEATH**

34994

2000

1 PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>			c. LENGTH OF STAY IN 1b <b>3 MOS 2 DAYS</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>MEMORIAL HOSPITAL, CUMBERLAND, MD.</b>				d. STREET ADDRESS <b>537 N. CENTRE STREET</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First <b>JOSEPH W.</b> Middle <b>MARTIN</b> Last <b>MARTIN</b>				4 DATE OF DEATH Month <b>APRIL</b> Day <b>2</b> Year <b>1968</b>			
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> SEPARATED <input type="checkbox"/>	8. DATE OF BIRTH <b>2-13-1912</b>		9. AGE (In years lost birthday) <b>56</b> yrs	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CARPENTER</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>CUMBERLAND, MD.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>DOMINIC A. MARTIN</b>				14. MOTHER'S MAIDEN NAME <b>EMMA HELMSTETER</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO		17. INFORMANT <b>MEMORIAL HOSPITAL, CUMBERLAND, MD.</b>			
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Thrombosis</i> DUE TO <i>Portul Canal Thrombosis</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Spontaneous due to disease</i> (c)							INTERVAL BETWEEN ONSET AND DEATH <i>1 month</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <i>July</i> , 1968 to <i>April 2</i> , 1968, that (I) (we) last saw the deceased alive on <i>April 1</i> , 1968, and that death occurred at <i>6:40 AM</i> from causes and on the date stated above.							
22a. SIGNATURE <i>Blane M. Schindler</i>				M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED <i>April 4/68</i>	
22c. PHYSICIAN'S NAME (Type) <b>DR. BLANE M. SCHINDLER</b>				22d. ADDRESS <b>43 GREENE ST., CUMBERLAND, MD.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>4/5/68</i>		23c. NAME OF CEMETERY OR CREMATORY <i>St. Peter &amp; Paul Cem.</i>		23d. LOCATION (City or Town) (County) (State) <i>Cumberland MD</i>	
24. FUNERAL DIRECTOR <i>Louis Stern Inc. Cumb. MD</i>				25a. REC'D BY REGISTRAR DATE <b>APR 4 - 1968</b>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



# FOR STATE HEALTH DEPT.

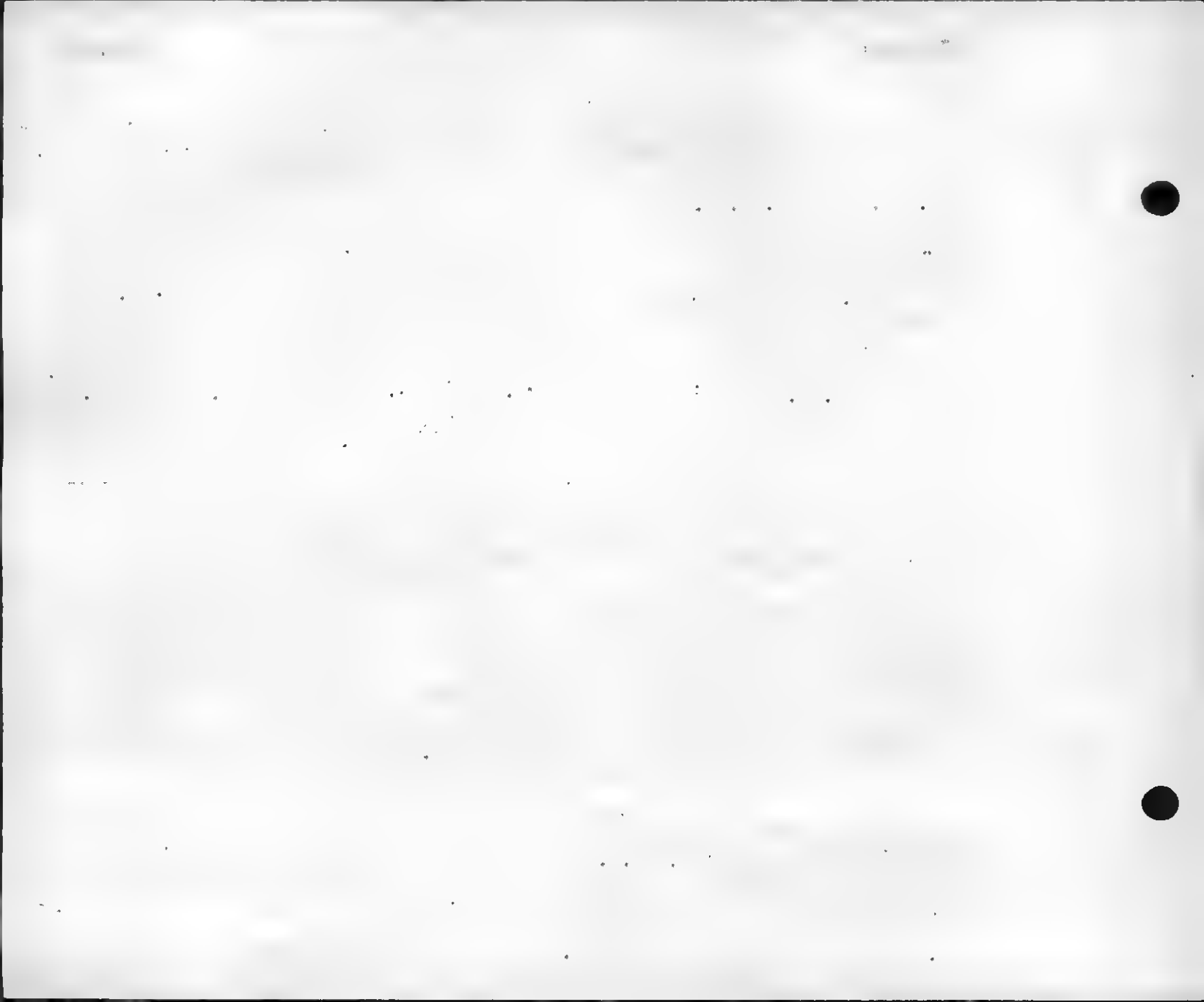
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

## DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

### MEDICAL EXAMINER'S CERTIFICATE OF DEATH

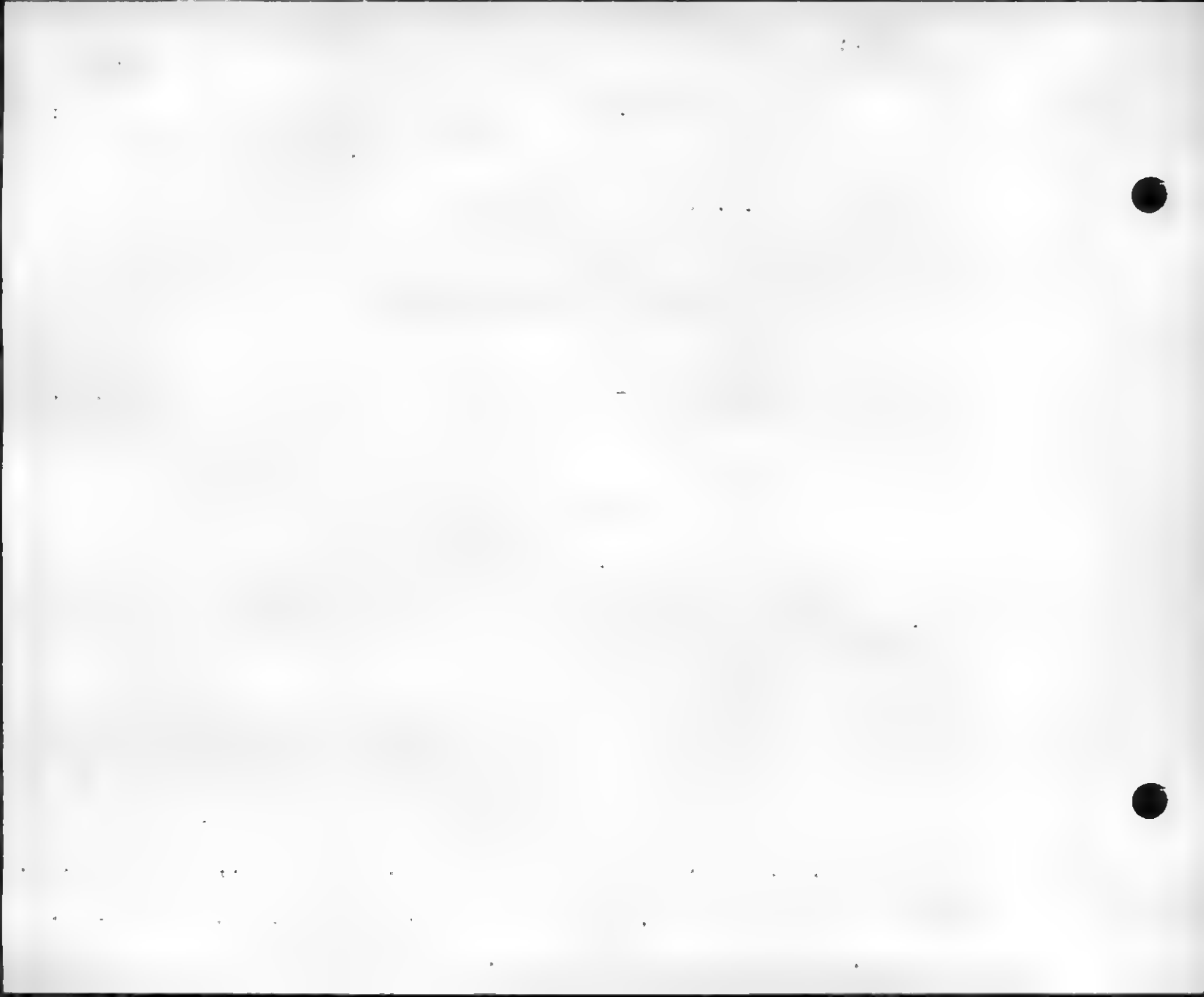
1 DECEASED NAME (Type or Print) First <i>Janes</i> Middle <i>Alexander</i> Last <i>McCourt</i>			2a DATE KNOWN OF DEATH Month <i>APRIL</i> Day <i>23</i> Year <i>1968</i>			2b HOUR <i>6:00 AM</i>		
3 SEX <i>Male</i>	4 RACE <i>White</i>	5 DATE OF BIRTH <i>March 27, 1920</i>	6 AGE (in years last birthday) <i>48</i> YRS	7 UNDER 1 YEAR MONTHS <i>0</i> DAYS <i>0</i>	8 UNDER 24 HRS HOURS <i>0</i> MIN. <i>0</i>	2c DATE PRONOUNCED DEAD Month <i>APRIL</i> Day <i>23</i> Year <i>1968</i>		
7a BIRTHPLACE (State or foreign country) <i>W. Va.</i>		7b CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9 COUNTY OF DEATH <i>Allegany</i> Md		
10 CITY OR TOWN OF DEATH <i>Cumberland,</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>321 Fort Hill Ave</i>				12a USUA. OCCUPATION (Kind of work done during most of work ing life, even if retired) <i>Laborer</i>		12b KIND OF BUSINESS OR INDUSTRY <i>Silk</i>
13a U.S.A. RESIDENCE (Where deceased lived f institution: Residence before adm ssion) STATE <i>Id.</i>		13b COUNTY <i>Allegany</i>	13c CITY OR TOWN <i>Cumberland,</i>		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e STREET AND NUMBER <i>321 Fort Hill Ave.</i>		
14 FATHER'S NAME First <i>Adam</i> Middle <i>McCourt</i> Last <i>McCourt</i>			15 MOTHER'S MAIDEN NAME First <i>Elizabeth</i> Middle <i>Feaster</i> Last <i>Feaster</i>					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>Yes</i>		16b SOCIAL SECURITY NO <i>217-10-1848</i>		17 INFORMANT <i>Mr. Daniel J. McCourt</i>		ADDRESS <i>Cum. Id. 182 N. Centre St.</i>		
18 CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>ASPHYXIATION, ASPIRATION OF STOMACH CONTENTS</i> DUE TO, OR AS A CONSEQUENCE OF <i>ALCOHOLISM</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>25</i>
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (c) <i>3222</i>								
19a DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY Month, Day, Year HOUR A.M. <i>19</i> P.M.		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (At home farm, street, factory, office building, etc.)		21f LOCATION Street or R.F.D. No		City or Town		County
22a I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspect an <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE <i>Benedict Skitarelic</i> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b DATE SIGNED		
EXAMINER'S NAME (Type) <i>BENEDICT SKITARELIC, M.D.</i>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		<i>APRIL 23, 1968</i>		
				ADDRESS (Street, city, town, or county) <i>CUMBERLAND, MARYLAND</i>				
23a BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b DATE <i>4/26/68</i>		23c NAME OF CEMETERY OR CREMATORY <i>Hillcrest Burial Park</i>		23d LOCATION (City or Town) (County) (State) <i>Cumberland, Allegany Id.</i>		
24 FUNERAL DIRECTOR <i>H. Wayne George Cumberland, Md.</i>				25a REC'D BY REGISTRAR DATE <i>APR 29 1968</i>		25b REGISTRAR'S SIGNATURE <i>Charles Judge</i>		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2) and direct, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2) should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

5001										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										CERTIFICATE OF DEATH										05002																			
1. DECEASED-NAME (Type or print)					First Middle Last					2a. DATE OF DEATH					2b. HOUR																																		
GIBSON					Alexander					MEEK					APRIL					Month Day Year					1968					1:25 PM																			
3 SEX					4. RACE					5. DATE OF BIRTH					6 AGE (In years last birthday)					IF UNDER 1 YEAR					IF UNDER 24 HRS.																								
MALE					WHITE					JANUARY 15, 1892					76					MONTHS					DAYS					HOURS					MIN														
7a. BIRTHPLACE (State or foreign country)					7b. CITIZEN OF WHAT COUNTRY?					8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>					9. COUNTY OF DEATH										Md.																								
MARYLAND					U.S.A.										ALLEGANY																																		
10 CITY OR TOWN OF DEATH					11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)					12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)					12b KIND OF BUSINESS OR INDUSTRY																																		
CUMBERLAND					MEMORIAL HOSPITAL					Foreman					Laundry																																		
13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before adm-ssion) STATE					13b COUNTY					13c CITY OR TOWN					13d. RESIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					13e STREET AND NUMBER																													
MARYLAND					ALLEGANY					CUMBERLAND										556 550 WINIFRED ROAD																													
14 FATHER'S NAME					15. MOTHER'S MAIDEN NAME																																												
ALEXANDER					MEEK					Unknown					Unknown																																		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown					16b. SOCIAL SECURITY NO					17 INFORMANT					Address																																		
					214-05-6146					MEMORIAL HOSPITAL, CUMBERLAND, MD.																																							
18 CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c))																				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																													
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Brownian pneumonia</u>																																																	
DUE TO, OR AS A CONSEQUENCE OF																																																	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Congenitive heart failure</u>																																																	
DUE TO, OR AS A CONSEQUENCE OF (c)																																																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Atherosclerosis treated with esophageal myotomy</u>																																																	
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED										20a. AUTOPSY?										20b. F. YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?																			
5 March 1968										Atherosclerosis										YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																													
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)										21b. TIME OF INJURY										21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)																													
										HOUR A.M. Month Day Year P.M. 19																																							
21a. INJURY OCCURRED										21b. PLACE OF INJURY (AT HOME FARM STREET FACTORY) OFFICE BUILDING, ETC.										21f. LOCATION Street or R.F.D. No City or Town County State																													
While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>																																																	
22a. I certify that (I) (this hospital) attended the deceased from 11:30 AM, 1968, to 2:00 PM, 1968, that (I) (we) lost the deceased alive on 2 April 1968, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.																																																	
22b. SIGNATURE																				22c. DATE SIGNED																													
F. Miltenberger M.D.																				21 Apr 68																													
22d. PHYSICIAN'S NAME (Type)																				22e. ADDRESS																													
DR. F. MILTENBERGER																				122 SO. CENTER ST., CUMBERLAND, MD.																													
23a. BURIAL, CREMATION, REMOVAL (Specify)										23b. DATE										23c. NAME OF CEMETERY OR CREMATORY										23d. LOCATION (City or Town) (County) (State)																			
										4/24/68										SS. Peter & Paul Cemetery										Cumberland, Allegany, Md.																			
24. FUNERAL DIRECTOR																				25a. REC'D BY REGISTRAR										25b. REGISTRAR'S SIGNATURE																			
H. Wayne George																				Cumberland, Md.										APR 25 1968										James Judge									





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

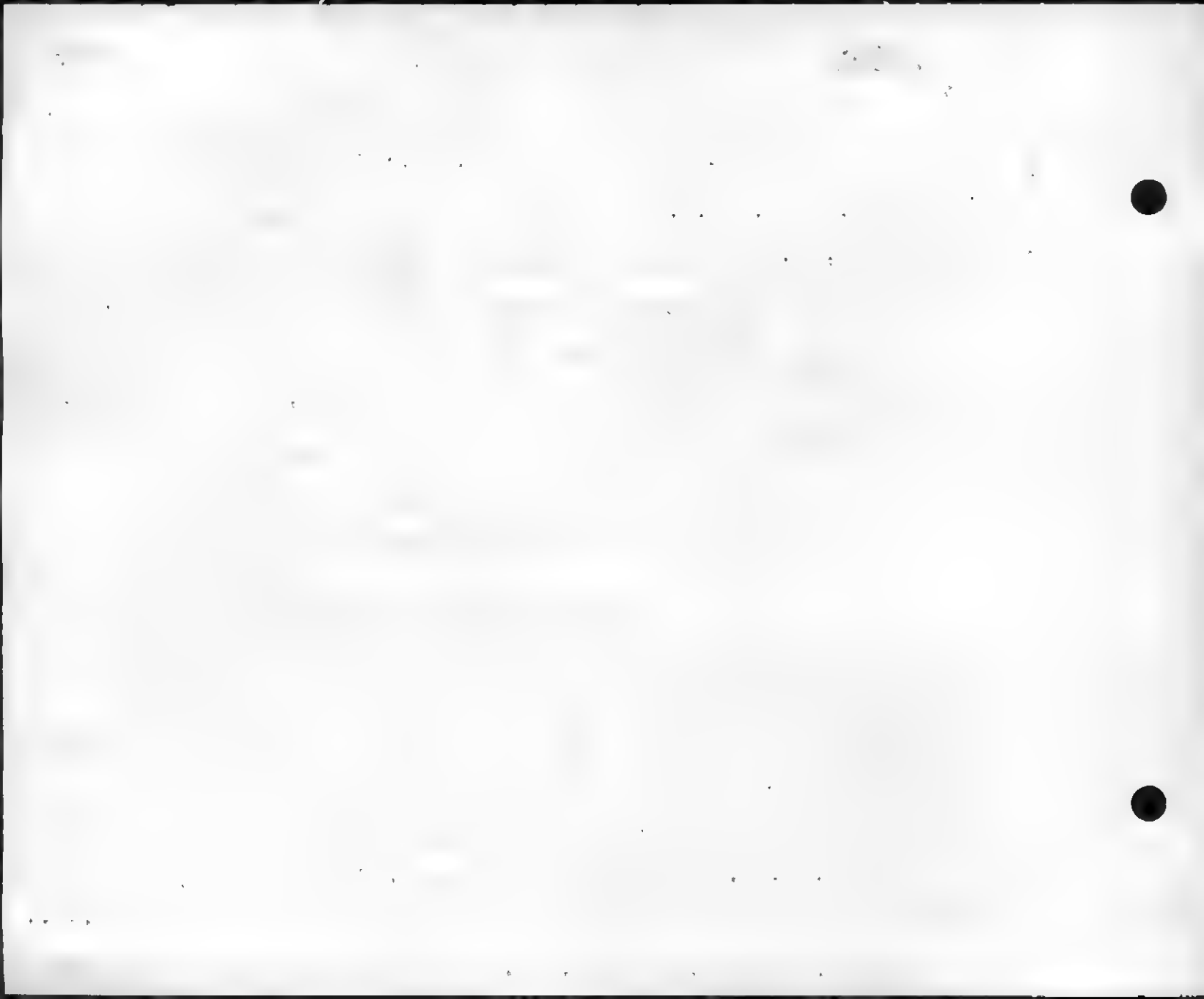
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1

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**  
**CERTIFICATE OF DEATH**

5002

1 DECEASED NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH Month Day Year			2b. HOUR		
UNGER					MELLOTT	APRIL 21 1968			4:00		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
MALE		WHITE		AUG. 20, 1878		89 YRS		MONTHS	DAYS	HOURS MIN	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
NEEDMORE, PENNA.		U.S.A.				ALLEGANY Md.					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
CUMBERLAND, MD.			MEMORIAL HOSPITAL			Contractor			Building		
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER	
MARYLAND			ALLEGANY			LA VALE		YES		56 LA VALE BLVD.	
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First	Middle	Last
JOSHUA					MELLOTT	MARY					LAKE
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT					Address
No						MEMORIAL HOSPITAL, CUMBERLAND, MD.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Terminal cardiac failure</u>										<u>5 days</u>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last										<u>3 years</u>	
(b) <u>A.S. Lent disease</u>										<u>?</u>	
(c) <u>Gen. arteriosclerosis</u>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <u>19 Apr. 1968</u> , to <u>21 Apr. 1968</u> , that (I) <u>(we)</u> last saw the deceased alive on <u>20 Apr. 1968</u> , and that in (my) <u>(our)</u> opinion death occurred on the date and hour and from the causes stated above. (I) <u>(we)</u> (did) (did not) view the body after death.											
22b. SIGNATURE <u>W. A. Van Ormer, M.D.</u>						DEGREE ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED <u>21 Apr. 68</u>			
22d. PHYSICIAN'S NAME (Type) DR. W. A. VAN ORMER						22e. ADDRESS 122 NO. CENTRE STREET, CUMBERLAND MD					
23a. BURIAL CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
Burial			April 23, 1968		Hyndman Cemetery		Hyndman, Bedford Co., Pa.				
24. FUNERAL DIRECTOR Harvey H. Zeigler, Hyndman, Pa.						25a. REC'D BY REGISTRAR DATE APR 26 1968		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			



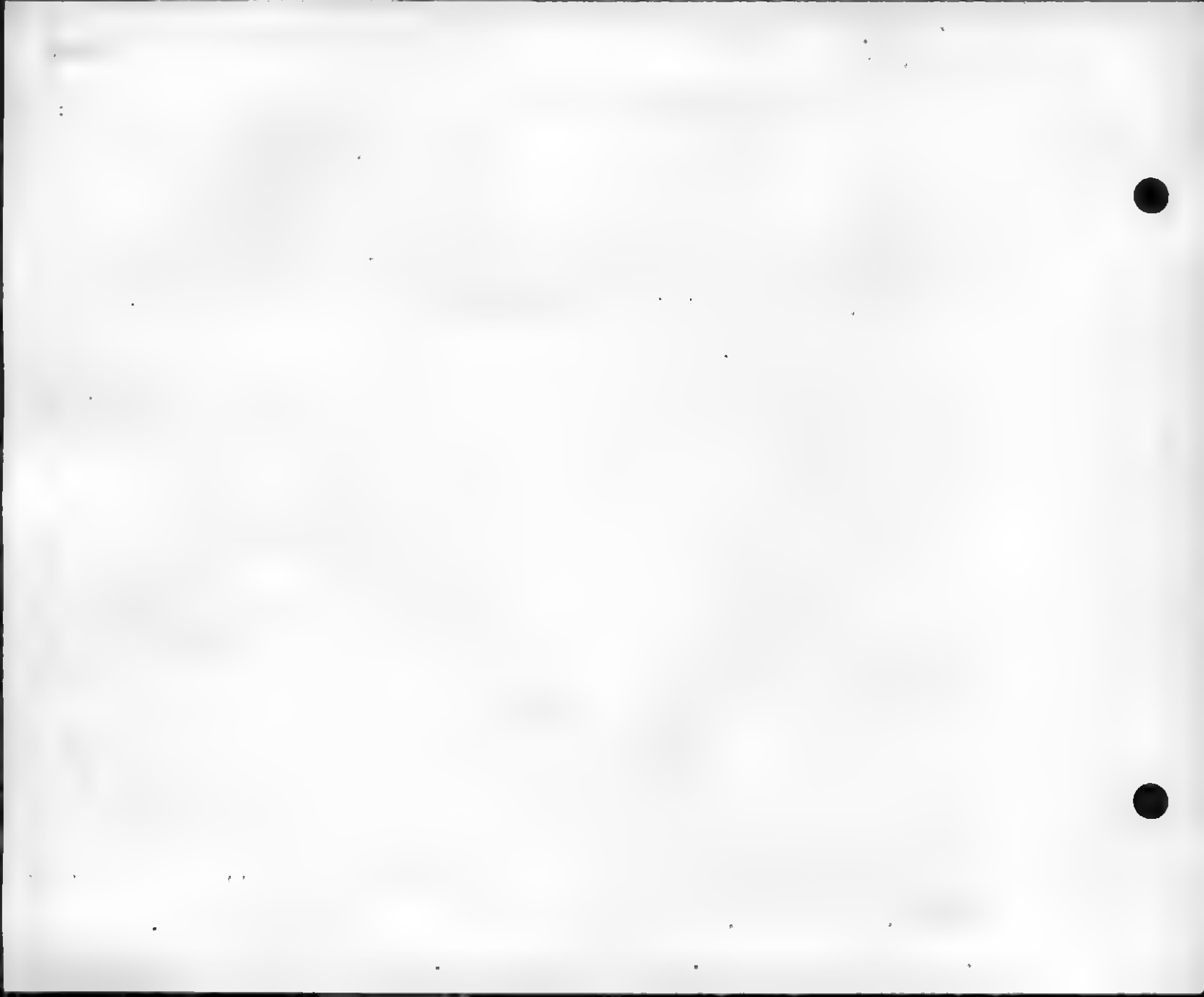
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (Pages 1 and 2) and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 11-5(4)  
30M REV 1/68

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
**CERTIFICATE OF DEATH**

<div style="font-size: 2em; font-weight: bold; margin-bottom: 5px;">55003</div> <div style="font-size: 1.5em; font-weight: bold;">1</div>			<div style="font-size: 1.5em; font-weight: bold;">1</div>			<div style="font-size: 1.5em; font-weight: bold;">1</div>								
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR					
Michael Thomas MAGROGAN						APRIL 20, 1968			4:33 PM					
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
MALE		WHITE		APRIL 20, 1968			YRS.		MONTHS		DAYS			
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH			Md.		
MARYLAND			USA						ALLEGANY					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY					
CUMBERLAND			MEMORIAL HOSPITAL			----- none								
13a. USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET AND NUMBER		
MD.			P. G.			HYATTSVILLE			YES <input type="checkbox"/> NO <input type="checkbox"/>			3807 65TH AVE.		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME											
First Middle Last			First Middle Last											
THEODORE J. MAGROGAN			JANET ALLEN											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO			17. INFORMANT			Address					
						MEMORIAL HOSPITAL, CUMBERLAND, MD.								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Phenakality. Bugt. 1A 70g.</u>														
DUE TO, OR AS A CONSEQUENCE OF														
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last														
DUE TO, OR AS A CONSEQUENCE OF														
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
						YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)								
			HOUR A.M. Month Day Year											
21d. INJURY OCCURRED			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)			21f. LOCATION			Street or R.F.D. No.			City or Town		
While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>														
22a. I certify that (I) (this hospital) attended the deceased from <u>4-20</u> , 19 <u>68</u> to <u>4-20</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>4-20</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.														
22b. SIGNATURE			22c. DATE SIGNED											
<u>Robert R. Brodell MD</u>			DEGREE			ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>			4-20-68					
22d. PHYSICIAN'S NAME (Type)			22e. ADDRESS											
DR. R. BRODELL			500 GREENE STREET, CUMBERLAND, MD.											
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town)			(County) (State)		
Burial			April 23, 1968			Gate Of Heaven			Silver Spring Mont. Maryland					
24. FUNERAL DIRECTOR			25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE								
F. Gasch's Sons 4739 Balt. Ave. Hyattsville, Md			APR 24 1968			<u>Charles Judge</u>								



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1. DECEASED NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF DEATH MATED			2b. HOUR
Isabelle Johnson Mouse						Month Day Year			:15 A M
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (in years last birthday)	7 MONTHS	8 YEARS	9 HOURS	10 MIN	2c. DATE PRONOUNCED DEAD	2d. HOUR
Female	White	May 15, 1902	65 YRS					Month Day Year	:15 A M
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Penna.		USA				Allegany Md.			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY
Cumberland			D.O.A. Memorial Hosp.			Housewife			Own Home
13a. USUAL RESIDENCE (Where deceased lived, if institution admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
Md.			Allegany			Cumberland			319 Bedford Street
14. FATHER'S NAME			15. MOTHER'S M.A.DEN NAME						
First Middle Last			First Middle Last						
Alfred E. Howell			Mary E. Harlan						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO			17. INFORMANT ADDRESS			
NO						Mr. Francis C. Mouse, Cumberland, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)								2 Years	
DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
(b)									
DUE TO, OR AS A CONSEQUENCE OF									
(c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
				Hour A.M. P.M.					
21d. INJURY OCCURRED		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No City or Town County State					
WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/>									
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE				CHIEF MEDICAL EXAMINER				22b. DATE SIGNED	
EXAMINER'S NAME (Type)				ASSISTANT MEDICAL EXAMINER				Apr. 29, 1968	
Dr. Benedict Skitarelic, M.D.				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				Rt. 9, Cumberland	
ADDRESS (Street, city, town, or county)									
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		May 1, 1968		Hillcrest Burial Park		Cumberland, Allegany, Md.			
24. FUNERAL DIRECTOR ADDRESS				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
James F. Scarpelli, Cumberland, Md.				DATE MAY 2 1968		Charles Judge			

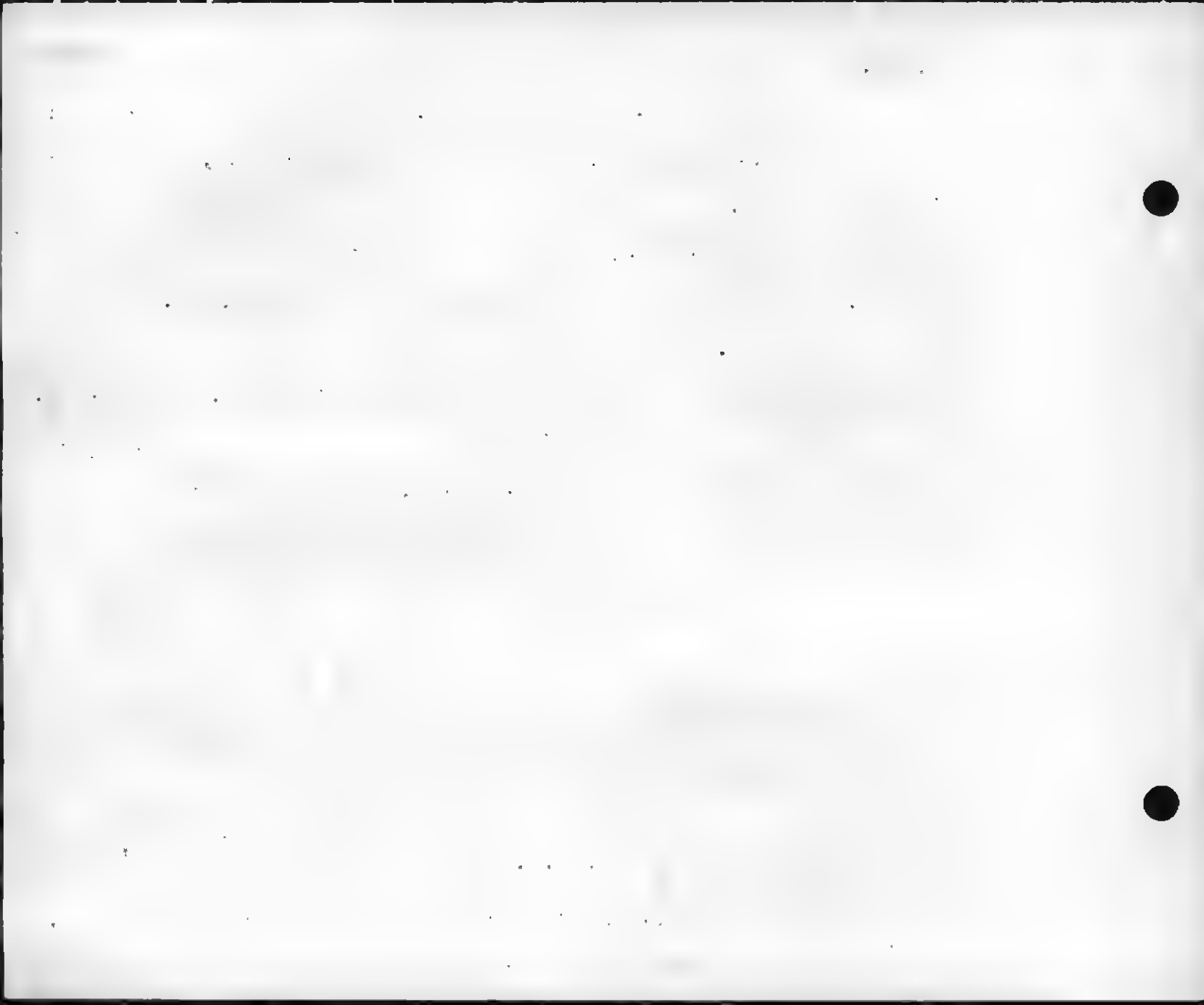


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FOR STATE HEALTH DEPT

Items 1-4-11-12-13-14-15-16-17-18-19-20-21-22-23-24-25-26-27-28-29-30-31-32-33-34-35-36-37-38-39-40-41-42-43-44-45-46-47-48-49-50-51-52-53-54-55-56-57-58-59-60-61-62-63-64-65-66-67-68-69-70-71-72-73-74-75-76-77-78-79-80-81-82-83-84-85-86-87-88-89-90-91-92-93-94-95-96-97-98-99-100-101-102-103-104-105-106-107-108-109-110-111-112-113-114-115-116-117-118-119-120-121-122-123-124-125-126-127-128-129-130-131-132-133-134-135-136-137-138-139-140-141-142-143-144-145-146-147-148-149-150-151-152-153-154-155-156-157-158-159-160-161-162-163-164-165-166-167-168-169-170-171-172-173-174-175-176-177-178-179-180-181-182-183-184-185-186-187-188-189-190-191-192-193-194-195-196-197-198-199-200-201-202-203-204-205-206-207-208-209-210-211-212-213-214-215-216-217-218-219-220-221-222-223-224-225-226-227-228-229-230-231-232-233-234-235-236-237-238-239-240-241-242-243-244-245-246-247-248-249-250-251-252-253-254-255-256-257-258-259-260-261-262-263-264-265-266-267-268-269-270-271-272-273-274-275-276-277-278-279-280-281-282-283-284-285-286-287-288-289-290-291-292-293-294-295-296-297-298-299-300-301-302-303-304-305-306-307-308-309-310-311-312-313-314-315-316-317-318-319-320-321-322-323-324-325-326-327-328-329-330-331-332-333-334-335-336-337-338-339-340-341-342-343-344-345-346-347-348-349-350-351-352-353-354-355-356-357-358-359-360-361-362-363-364-365-366-367-368-369-370-371-372-373-374-375-376-377-378-379-380-381-382-383-384-385-386-387-388-389-390-391-392-393-394-395-396-397-398-399-400-401-402-403-404-405-406-407-408-409-410-411-412-413-414-415-416-417-418-419-420-421-422-423-424-425-426-427-428-429-430-431-432-433-434-435-436-437-438-439-440-441-442-443-444-445-446-447-448-449-450-451-452-453-454-455-456-457-458-459-460-461-462-463-464-465-466-467-468-469-470-471-472-473-474-475-476-477-478-479-480-481-482-483-484-485-486-487-488-489-490-491-492-493-494-495-496-497-498-499-500-501-502-503-504-505-506-507-508-509-510-511-512-513-514-515-516-517-518-519-520-521-522-523-524-525-526-527-528-529-530-531-532-533-534-535-536-537-538-539-540-541-542-543-544-545-546-547-548-549-550-551-552-553-554-555-556-557-558-559-560-561-562-563-564-565-566-567-568-569-570-571-572-573-574-575-576-577-578-579-580-581-582-583-584-585-586-587-588-589-590-591-592-593-594-595-596-597-598-599-600-601-602-603-604-605-606-607-608-609-610-611-612-613-614-615-616-617-618-619-620-621-622-623-624-625-626-627-628-629-630-631-632-633-634-635-636-637-638-639-640-641-642-643-644-645-646-647-648-649-650-651-652-653-654-655-656-657-658-659-660-661-662-663-664-665-666-667-668-669-670-671-672-673-674-675-676-677-678-679-680-681-682-683-684-685-686-687-688-689-690-691-692-693-694-695-696-697-698-699-700-701-702-703-704-705-706-707-708-709-710-711-712-713-714-715-716-717-718-719-720-721-722-723-724-725-726-727-728-729-730-731-732-733-734-735-736-737-738-739-740-741-742-743-744-745-746-747-748-749-750-751-752-753-754-755-756-757-758-759-760-761-762-763-764-765-766-767-768-769-770-771-772-773-774-775-776-777-778-779-780-781-782-783-784-785-786-787-788-789-790-791-792-793-794-795-796-797-798-799-800-801-802-803-804-805-806-807-808-809-810-811-812-813-814-815-816-817-818-819-820-821-822-823-824-825-826-827-828-829-830-831-832-833-834-835-836-837-838-839-840-841-842-843-844-845-846-847-848-849-850-851-852-853-854-855-856-857-858-859-860-861-862-863-864-865-866-867-868-869-870-871-872-873-874-875-876-877-878-879-880-881-882-883-884-885-886-887-888-889-890-891-892-893-894-895-896-897-898-899-900-901-902-903-904-905-906-907-908-909-910-911-912-913-914-915-916-917-918-919-920-921-922-923-924-925-926-927-928-929-930-931-932-933-934-935-936-937-938-939-940-941-942-943-944-945-946-947-948-949-950-951-952-953-954-955-956-957-958-959-960-961-962-963-964-965-966-967-968-969-970-971-972-973-974-975-976-977-978-979-980-981-982-983-984-985-986-987-988-989-990-991-992-993-994-995-996-997-998-999-1000-1001-1002-1003-1004-1005-1006-1007-1008-1009-1010-1011-1012-1013-1014-1015-1016-1017-1018-1019-1020-1021-1022-1023-1024-1025-1026-1027-1028-1029-1030-1031-1032-1033-1034-1035-1036-1037-1038-1039-1040-1041-1042-1043-1044-1045-1046-1047-1048-1049-1050-1051-1052-1053-1054-1055-1056-1057-1058-1059-1060-1061-1062-1063-1064-1065-1066-1067-1068-1069-1070-1071-1072-1073-1074-1075-1076-1077-1078-1079-1080-1081-1082-1083-1084-1085-1086-1087-1088-1089-1090-1091-1092-1093-1094-1095-1096-1097-1098-1099-1100-1101-1102-1103-1104-1105-1106-1107-1108-1109-1110-1111-1112-1113-1114-1115-1116-1117-1118-1119-1120-1121-1122-1123-1124-1125-1126-1127-1128-1129-1130-1131-1132-1133-1134-1135-1136-1137-1138-1139-1140-1141-1142-1143-1144-1145-1146-1147-1148-1149-1150-1151-1152-1153-1154-1155-1156-1157-1158-1159-1160-1161-1162-1163-1164-1165-1166-1167-1168-1169-1170-1171-1172-1173-1174-1175-1176-1177-1178-1179-1180-1181-1182-1183-1184-1185-1186-1187-1188-1189-1190-1191-1192-1193-1194-1195-1196-1197-1198-1199-1200-1201-1202-1203-1204-1205-1206-1207-1208-1209-1210-1211-1212-1213-1214-1215-1216-1217-1218-1219-1220-1221-1222-1223-1224-1225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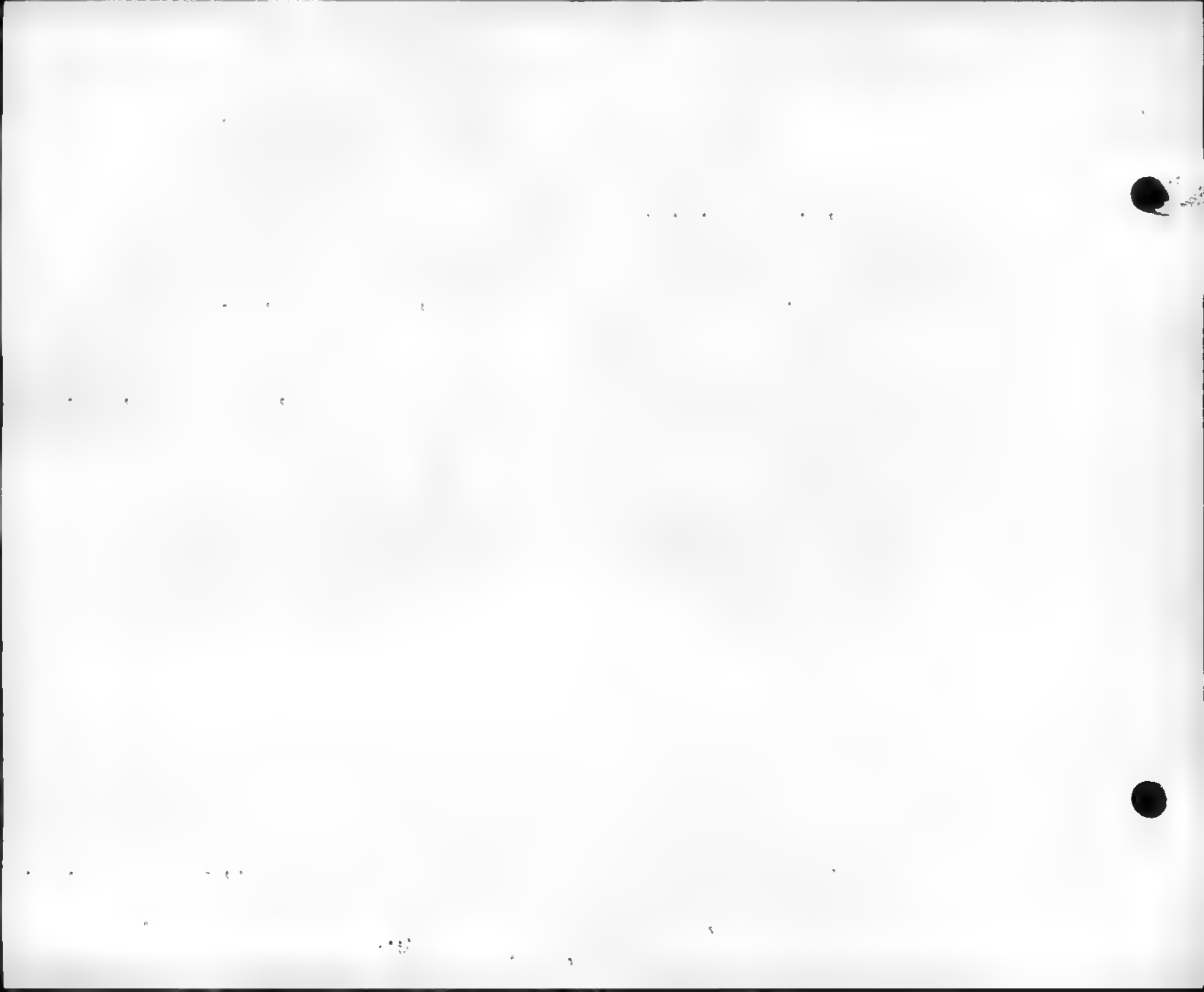
## CERTIFICATE OF DEATH

5006

1. DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH Month Day Year		2b. HOUR	
HOWARD				NESBITT	APRIL 26, 1968		5:25 AM	
3 SEX	4 RACE	5 DATE OF BIRTH			6 AGE (in years last birthday)	7 UNDER 1 YEAR		IF UNDER 24 HRS
FEMALE	WHITE	DECEMBER 15, 1893			74 YRS	MONTHS DAYS		HOURS MIN
7a BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH		Md.		
PIEDMONT, W. VA	U.S.A.			ALLEGANY				
10 CITY OR TOWN OF DEATH	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY			
CUMBERLAND	MEMORIAL HOSPITAL							
13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE	13b COUNTY	13c CITY OR TOWN	13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e STREET AND NUMBER				
CUMB. MD.	ALLEGANY	CUMBERLAND		RT. #3, BEDFORD ROAD				
14 FATHER'S NAME	First	Middle	Last	15 MOTHER'S M.A.D.E.N. NAME		First	Middle	Last
HERBERT			NESBITT	LAURA				PIERCE
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown	16b SOCIAL SECURITY NO		17 INFORMANT Address					
NO	UNKNOWN		MEMORIAL HOSPITAL, CUMBERLAND, MD.					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Myocardial infarction</u>								3 days
4107 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Coronary atherosclerosis and aneurysm</u>								2 months
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Cholelithiasis</u>								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Also had ischemic necrosis of small bowel.</u>								
19a DATE OF OPERATION	19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b TIME OF INJURY		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18)					
	HOUR A.M. Month Day Year P.M. 19							
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f LOCATION		Street or R.F.O. No.		City or Town	County
								State
22a I certify that (I) (this hospital) attended the deceased from <u>25 Apr</u> , 19 <u>68</u> , to <u>26 Apr</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>26 Apr</u> , 19 <u>68</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.								
22b SIGNATURE <u>Miltenberger</u>				DEGREE	ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>	22c DATE SIGNED		
22d PHYSICIAN'S NAME (Type) DR. FRED MILTENBERGER				22e ADDRESS 122 SO. CENTRE ST., CUMBERLAND, MD.				
23a BURIAL, CREMATION, REMOVAL (Specify)	23b DATE	23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town)		(County)		(State)
BURIAL	APRIL 29, 1968	Rose Hill Cemetery		Cumberland, Md.				
24 FUNERAL DIRECTOR	ADDRESS		25a REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE			
Byron Kight	Cumberland, Md.		DATE MAY 3 1968		<u>John A. Jones</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH											
1. DECEASED NAME (Type or print)		First		Middle		Last		2a. DATE OF DEATH Month Day Year		2b. HOUR A M	
Catherine		Ellen		Nisbet		April		Month 13 Day 1968		9:50	
3. SEX Female		4. RACE White		5. DATE OF BIRTH August 10, 1884		6. AGE (In years last birthday) 83 YRS.		IF UNDER YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) Scotland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Allegany Md					
10. CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 37 Race Street				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Own Home			
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Maryland		13b. COUNTY Allegany		13c. CITY OR TOWN Cumberland		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 37 Race Street			
14. FATHER'S NAME First Middle Last John Fitzpatrick				15. MOTHER'S MAIDEN NAME First Middle Last Hannah Haughie							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service) no		16b. SOCIAL SECURITY NO.		17. INFORMANT Address Mrs. Helen Schwenninger, Daughter Cumberland, Md.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Arteriosclerotic cardio-vascular disease 129 DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 years	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 4											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from 7 - 28, 19 65 to 4 - 14, 19 68, that (I) (we) last saw the deceased alive on 4 - 13, 19 68, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Ralph W. Ballin		DEGREE M.D.		ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED 4-15-68					
22d. PHYSICIAN'S NAME (Type) Ralph W. Ballin, M.D.		22e. ADDRESS 62 Greene St. Cumberland, Md 21502									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Apr. 16, 1968		23c. NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery		23d. LOCATION (City or Town) (County) (State) Cumberland, Allegany, Md.					
24. FUNERAL DIRECTOR James F. Scarpelli, Cumberland, Md.				25a. REC'D BY REGISTRAR DATE APR 18 1968		25b. REGISTRAR'S SIGNATURE Charles Judge					

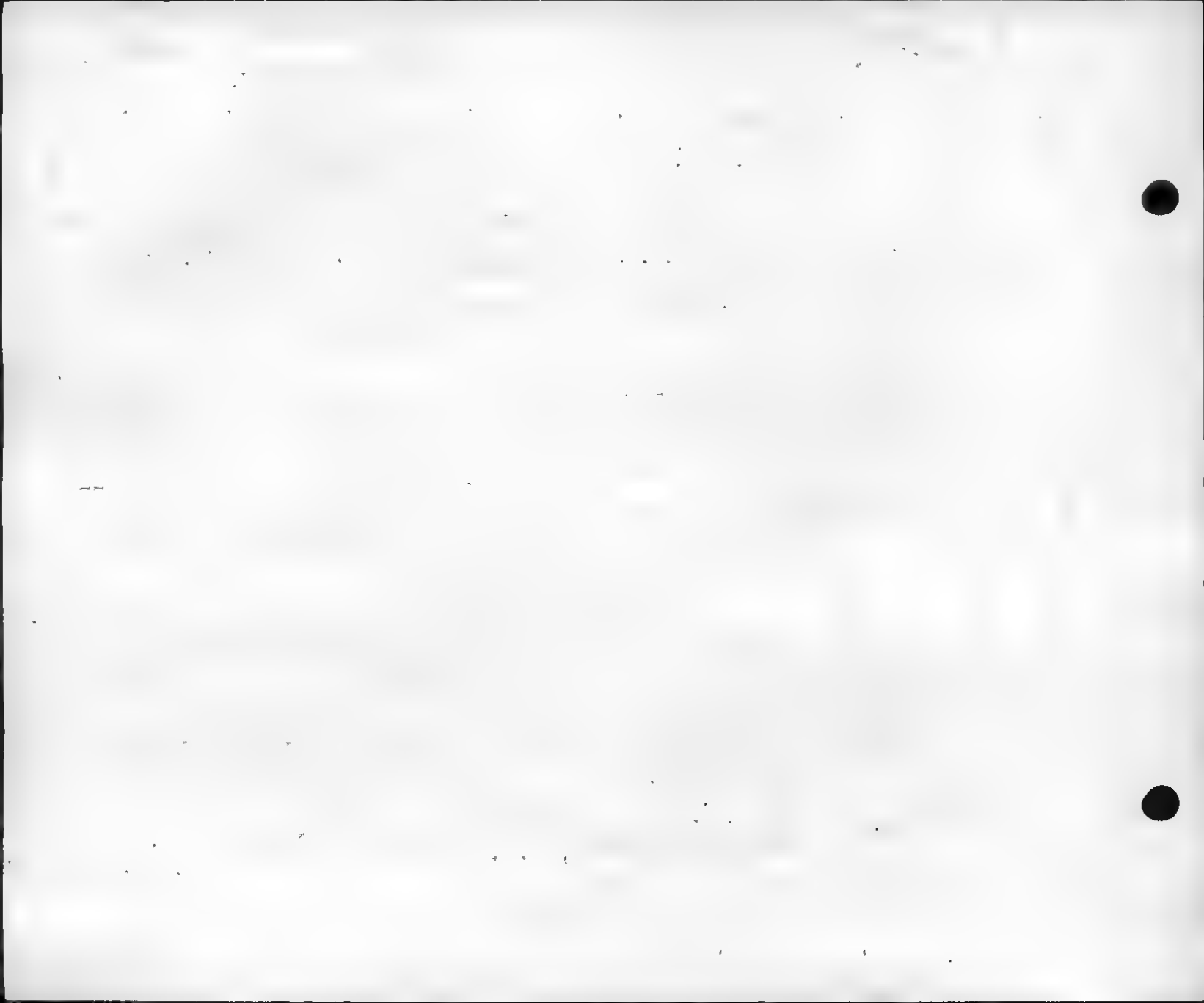


FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1 DECEASED NAME (Type or Print)			First			Middle			Last		
Nelson			Henry			Olmstead					
3 SEX		4 RACE		5. DATE OF BIRTH		6 AGE (in years last birthday)		7 UNDER YEAR		IF UNDER 24 HRS	
MALE		WHITE		JULY 25, 1892		75 YRS		MONTHS		DAYS	
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		9 COUNTY OF DEATH		2c DATE KNOWN OF DEATH		2b HOUR	
KANSAS		USA		WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		ALLEGANY		APRIL 2, 1968		M	
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b KIND OF BUSINESS OR INDUSTRY		
CUMBERLAND			D.O.A. MEMORIAL HOSPITAL			CO. HEAVY EQUIP.			EMPLOYEE		
3a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE			13b COUNTY			13c CITY OR TOWN			13d MADE CITY LIMITS?		
MARYLAND			ALLEGANY			CUMBERLAND			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14 FATHER'S NAME			15 MOTHER'S MAIDEN NAME			13e STREET AND NUMBER			13f CITY OR TOWN		
OLIVER			OLMSTEAD			ETTA			BILLE		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b SOCIAL SECURITY NO			17 INFORMANT			ADDRESS		
NO			511-30-6685			Mrs Dorothy THOMPSON			RED#3 JILL ROAD		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)										CORONARY OCCLUSION	
4109										STUPOR	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										CORONARY SCLEROSIS	
(b)											
DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
+ 200											
19a DATE OF OPERATION				19b CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY?			
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>				21b TIME OF INJURY Month, Day, Year				21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
CAUSE OF DEATH				HOUR A.M. P.M.				19			
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>				21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f LOCATION Street or R.F.D. No			
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>								City or Town			
								County			
								State			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE				BENEDICT SKITARELIC, M.D.				22b DATE SIGNED			
EXAMINER'S NAME (Type)								APRIL 2, 1968			
								ADDRESS (Street, city, town, or county)			
								CUMBERLAND, MARYLAND			
23a BURIAL CREMATION, REMOVAL (Specify)				23b DATE				23c NAME OF CEMETERY OR CREMATORY			
BURIAL				5 APRIL 68				DEAY CEMETERY			
24 FUNERAL DIRECTOR				ADDRESS				25a REC'D BY REGISTRAR			
H. LEE SILCOX				404 DECATUR ST, CUMBERLAND MD.				APR 4 - 1968			
								25b REGISTRAR'S SIGNATURE			
								Charles Judge			



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

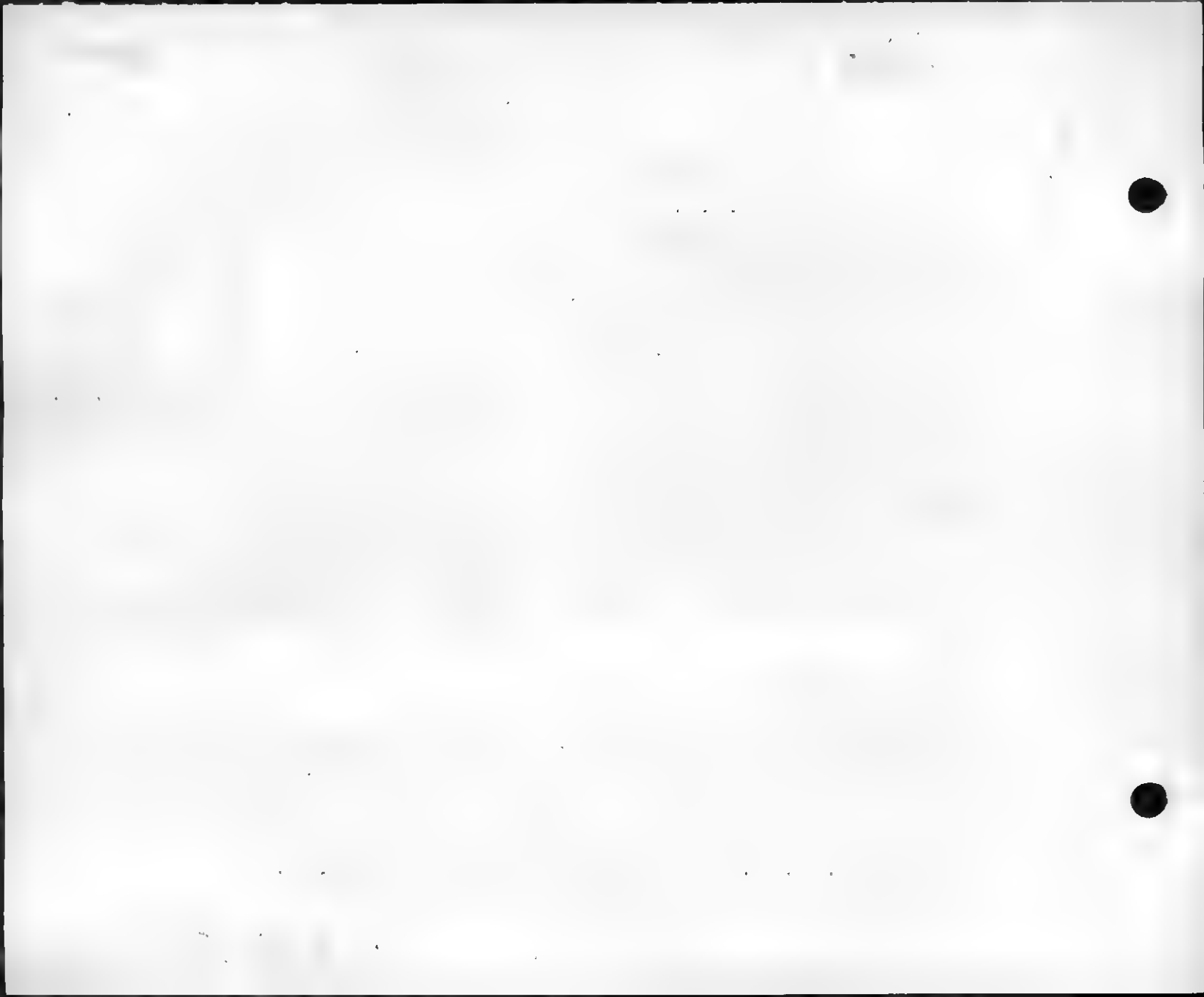
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 4 and 5 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

15008

1. DECEASED NAME (Type or print) First Middle Last LONIE O'NEAL			2a. DATE OF DEATH Month Day Year 4 20 68			2b. HOUR 8:00AM	
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH 9-28-84		6. AGE (In years lost birthday) 83 YRS.	
7a. BIRTHPLACE (State or foreign country) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH ALLEGANY Md.	
10. CITY OR TOWN OF DEATH CUMBERLAND		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) MEMORIAL HOSPITAL		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE MARYLAND		13b. COUNTY ALLEGANY		13c. CITY OR TOWN CUMBERLAND		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER 23 VIRGINIA AVENUE		14. FATHER'S NAME First Middle Last DANIEL LEASURE		15. MOTHER'S MAIDEN NAME First Middle Last JENNIE HUFFMAN			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown NO		16b. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT Address MEMORIAL HOSPITAL CUMBERLAND, MD.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> 4109 DUE TO, OR AS A CONSEQUENCE OF Conditions if any, which gave rise to immediate cause (a), stating the underlying cause lost. 427 (b) DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) <u>Diabetes Mellitus</u>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 8 days
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC.)		21f. LOCATION Street or RFD No City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 7/3/60, 19 to 4/20/68, 19 that (I) (we) last saw the deceased alive on 4/20/68, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Dr. R. J. Williams</u>		22c. DATE SIGNED 9/28/68		22d. PHYSICIAN'S NAME (Type) DR. R. J. WILLIAMS		22e. ADDRESS CUMBERLAND, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Apr. 23, 1968		23c. NAME OF CEMETERY OR CREMATORY Pleasant Grove Cemetery		23d. LOCATION (City or Town) (County) (State) Cumberland Allegany, Md.	
24. FUNERAL DIRECTOR James F. Scarielli, Cumberland, Md.				25a. REC'D BY REGISTRAR DATE MAY 2 1968		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

MEDICAL CERTIFICATION





# FOR STATE HEALTH DEPT.

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1 DECEASED NAME (Type or Print)			First Middle Last			2a DATE KNOWN OF DEATH			2b MONTH DAY YEAR HOUR		
REBECCA JANE ORNDORFF						APRIL 21, 1968			9:25 PM		
3 SEX	4 RACE	5. DATE OF BIRTH	6 AGE (In years last birthday)	7 UNDER 1 YEAR		IF UNDER 24 HRS		2c DATE PRONOUNCED DEAD		2d HOUR	
FEMALE	WHITE	OCT. 14, 1946	21 YRS	MONTHS	DAYS	HOURS	MIN	APRIL 21, 1968		9:40 PM	
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			12b KIND OF BUSINESS OR INDUSTRY		
VIRGINIA		USA				ALLEGANY			COLLEGE		
10. CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b KIND OF BUSINESS OR INDUSTRY		
RED FLINTSTONE			ROUTE 40			STUDENT			COLLEGE		
13a. USUAL RESIDENCE (Where deceased lived, if institution-Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d INSIDE CITY, APTS?		
W. VA.			BERKELEY			MARTINSBURG			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14 FATHER'S NAME			15 MOTHER'S MAIDEN NAME			16a WAS DECEASED EVER IN U.S. ARMED FORCES?			16b SOCIAL SECURITY NO		
JAMES S. ORNDORFF			GLADYS K. KIRBY			NO			232 72 7638		
17. INFORMANT			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED?		
Gladys K. JAMES/S. ORNDORFF			PART 1 DEATH WAS CAUSED BY:			APRIL 21, 1968			PASSENGER IN TWO CAR COLLISION		
			IMMEDIATE CAUSE (a)								
			DUE TO, OR AS A CONSEQUENCE OF								
			(b)								
			DUE TO, OR AS A CONSEQUENCE OF								
			(c)								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
20a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>			21a TIME OF INJURY Month, Day, Year			21b HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			21c LOCATION Street or R.F.D. No		
CAUSE OF DEATH			9:25 PM			APRIL 21, 1968			PASSENGER IN TWO CAR COLLISION		
21d INJURY OCCURRED			21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f LOCATION Street or R.F.D. No			City or Town		
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			Rt. # 40			two miles west of FLINTSTONE, ALLEGANY, MARYLAND					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE			BENEDICT SKITARELIC, M.D.			CHIEF MEDICAL EXAMINER			22b DATE SIGNED		
									APRIL 21, 1968		
EXAMINER'S NAME (Type)			BENEDICT SKITARELIC, M.D.			DEPUTY MEDICAL EXAMINER			ADDRESS (Street, city, town or county)		
									CUMBERLAND, MARYLAND		
23a BURIAL, CREMATION, REMOVAL (Specify)			23b DATE			23c NAME OF CEMETERY OR CREMATORY			23d LOCATION (City or town) (County) (State)		
BURIAL			4/24/68			FALLING WATERS CEM.			SPRING MILLS W. VA.		
24 FUNERAL DIRECTOR			25a REC'D BY REG. STRAR			25b REGISTRAR'S SIGNATURE					
HOWARD K. BROWN			MARTINSBURG, W. VA.			APR 24 1968			Charles Judge		



FOR STATE  
HEALTH DEPT.

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. DECEASED NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF DEATH			2b. HOUR		
SUSAN LINDA OWENS						Month Day Year			9:25 P M		
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE in years (last birthday)	7 UNDER 1 YEAR		IF UNDER 24 HRS		2c. DATE PRONOUNCED DEAD		2d. HOUR	
FEMALE	WHITE	Nov. 17, 1947	20 YRS	MONTHS	DAYS	HOURS	MIN	Month Day Year		9:40 P M	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
MASS.		USA				ALLEGANY Md					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY		
RFD FLINTSTONE			ROUTE 40			STUDENT			COLLEGE		
13a. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN		13d. INSIDE CITY, J.M. 157		13e. STREET AND NUMBER	
VIRGINIA			FAIRFAX			FALLS CHURCH		VA		2902 LABELLA WALK	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME								
First Middle Last			First Middle Last								
RALPH W. OWENS			MARY VIRGINIA SHARPE								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS					
NO			UNKNOWN			RALPH W. OWENS FALLS CHURCH, VA					
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b) and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)										SUDDEN	
DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.										(AUTO ACCIDENT)	
DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?			
8/64								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>				21b. TIME OF INJURY Month Day Year				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
CAUSE OF DEATH				9:25 P.M. APRIL 21, 1968				PASSENGER IN TWO CAR COLLISION			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No City or Town County State			
				RT. # 40, TWO MILES WEST OF FLINTSTONE, ALLEGANY, MARYLAND							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
22b. DATE SIGNED											
ACTUAL SIGNATURE				Benedict Skitarelic				M.D.			
EXAMINER'S NAME (Type)				BENEDICT SKITARELIC, M.D.				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
								APRIL 21, 1968			
								ADDRESS (Street, city, town or county)			
								cumberland, maryland			
23a. BURIAL, CREMATION REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)			
BURIAL			4/24/68		FAIRFAX MEMORY GARDENS FAIRFAX			VIRGINIA			
24. FUNERAL DIRECTOR						ADDRESS			25a. REC'D BY REG STRAR		
CHARLES M. WEST						FAIRFAX, VA.			DATE APR 29 1968		
									25b. REG STRAR'S SIGNATURE		
									Charles Judge		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

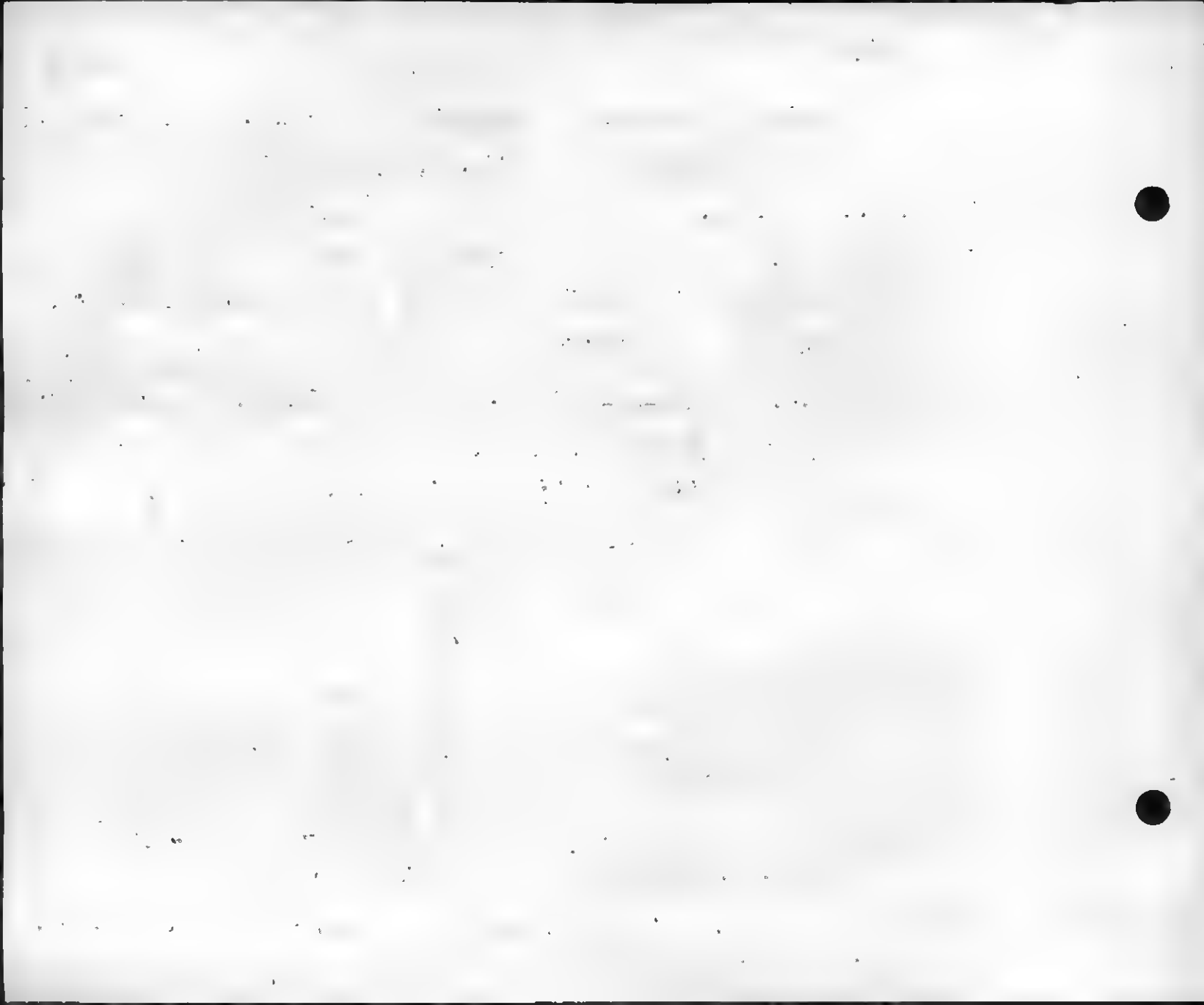
1M

05012

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

05013

1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH			2b. HOUR			
WILLIAM EDWARD PLUMMER						Month	Day	Year	2:58 P.M.			
3 SEX		4. RACE		5 DATE OF BIRTH		6 AGE (In years last birthday)		IF UNDER 1 YEAR				
MALE		WHITE		FEB. 6, 1906		62		MONTHS DAYS HOURS MIN				
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		12b. KIND OF BUSINESS OR INDUSTRY				
SHAFT, MD.		U.S.A.				ALLEGANY		KELLY TIRE				
10. CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY						
CUMBERLAND, MD.		MEMORIAL HOSPITAL		LABORER								
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER				
MARYLAND		ALLEGANY		CUMBERLAND				141 INDEPENDENCE ST.				
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S M.A.D.E.N NAME			First	Middle	Last	
CLYDE					PLUMMER	NETTIE				VIOLA	WINEBRENNER	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) NO			16b. SOCIAL SECURITY NO. N.A. 213-09-6464			17 INFORMANT			ST. CUMBERLAND, MD.			
						MR. JAMES E. PLUMMER, 141 INDEPENDENCE						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bacterial Shock</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Severe diffuse peritonitis due to rupture stomach?</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Generalized lymphatic invasion of stomach 7 yr</u> PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
											- 10 -	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18.)						
21d. INJURY OCCURRED Where <input type="checkbox"/> Not while at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)				21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from 3/18/1968, to 4/1/1968, that (I) (we) lost saw the deceased alive on 4/1/68, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE Walter N. Himmler, MD						DEGREE		ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED 4/3/68		
22d. PHYSICIAN'S NAME (Type) DR. W. A. HIMMLER						22e. ADDRESS CUMBERLAND, MD.						
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)					
BURIAL		4/4/68		ECKHART CEMETERY			ECKHART, ALLEGANY, MD.					
24. FUNERAL DIRECTOR MARILOU M. SOWERS, HAFER-SOWERS FUNERAL HOME, 60 W. MAIN, FROSTBURG						25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE William J. Jones				
DATE						APR 11 1968						



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH													
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201													
CERTIFICATE OF DEATH													
1 DECEASED-NAME (Type or print)			First Middle Last			2a DATE OF DEATH Month Day Year			2b HOUR P				
ROBERT			M. REECE			APRIL			25, 1968 11:50				
3 SEX		4 RACE		5 DATE OF BIRTH			6 AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		
MALE		WHITE		FEBRUARY 21, 1904			64 YRS.						
7a BIRTHPLACE (State or foreign country)			7b CITIZEN OF WHAT COUNTRY?			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH			Md.	
BALTIMORE, MD.			U.S.A.						ALLEGANY				
10 CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b KIND OF BUSINESS OR INDUSTRY				
CUMBERLAND, MD.			MEMORIAL HOSPITAL			RETIRED							
13a USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) STATE			13b COUNTY			13c CITY OR TOWN			13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e STREET AND NUMBER	
MARYLAND			ALLEGANY			WESTERNPORT						118 MAIN STREET	
14 FATHER'S NAME First Middle Last			15 MOTHER'S MAIDEN NAME First Middle Last										
SUTTON B. REECE			BLANCHE MURPHY										
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)			16b SOCIAL SECURITY NO.			17 INFORMANT Address							
						MEMORIAL HOSPITAL, CUMBERLAND, MD.							
18 CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>ventricular fibrillation</i>										3 years			
4109 DUE TO, OR AS A CONSEQUENCE OF <i>chronic obstructive pulmonary disease</i>										20 days			
DUE TO, OR AS A CONSEQUENCE OF <i>hypertension</i>										year			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)													
19a DATE OF OPERATION													
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED													
20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>													
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?													
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)													
21b TIME OF INJURY HOUR A.M. Month Day Year 19													
21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)													
21d INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/>													
21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.													
21f LOCATION Street or RFD No City or Town County State													
22a. I certify that (I) (this hospital) attended the deceased from April 5, 1968, to April 20, 1968, that (I) (we) last saw the deceased alive April 20, 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death													
22b SIGNATURE													
22c DATE SIGNED													
22d PHYSICIAN NAME (Type) DR. B. SCHINDLER													
22e ADDRESS 43 GREENE STREET, CUMBERLAND, MD.													
23a. BURIAL, CREMATION, REMOVAL (Specify)													
23b DATE 4/29/68													
23c. NAME OF CEMETERY OR CREMATORY Philo													
23d. LOCATION (City or Town) (County) (State) Westernport, Md.													
24. FUNERAL DIRECTOR E. J. Boal													
25a REC'D BY REGISTRAR DATE MAY 6 1968													
25b REGISTRAR'S SIGNATURE													





FOR STATE  
HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM-3. Page 5 may be retained for your files.

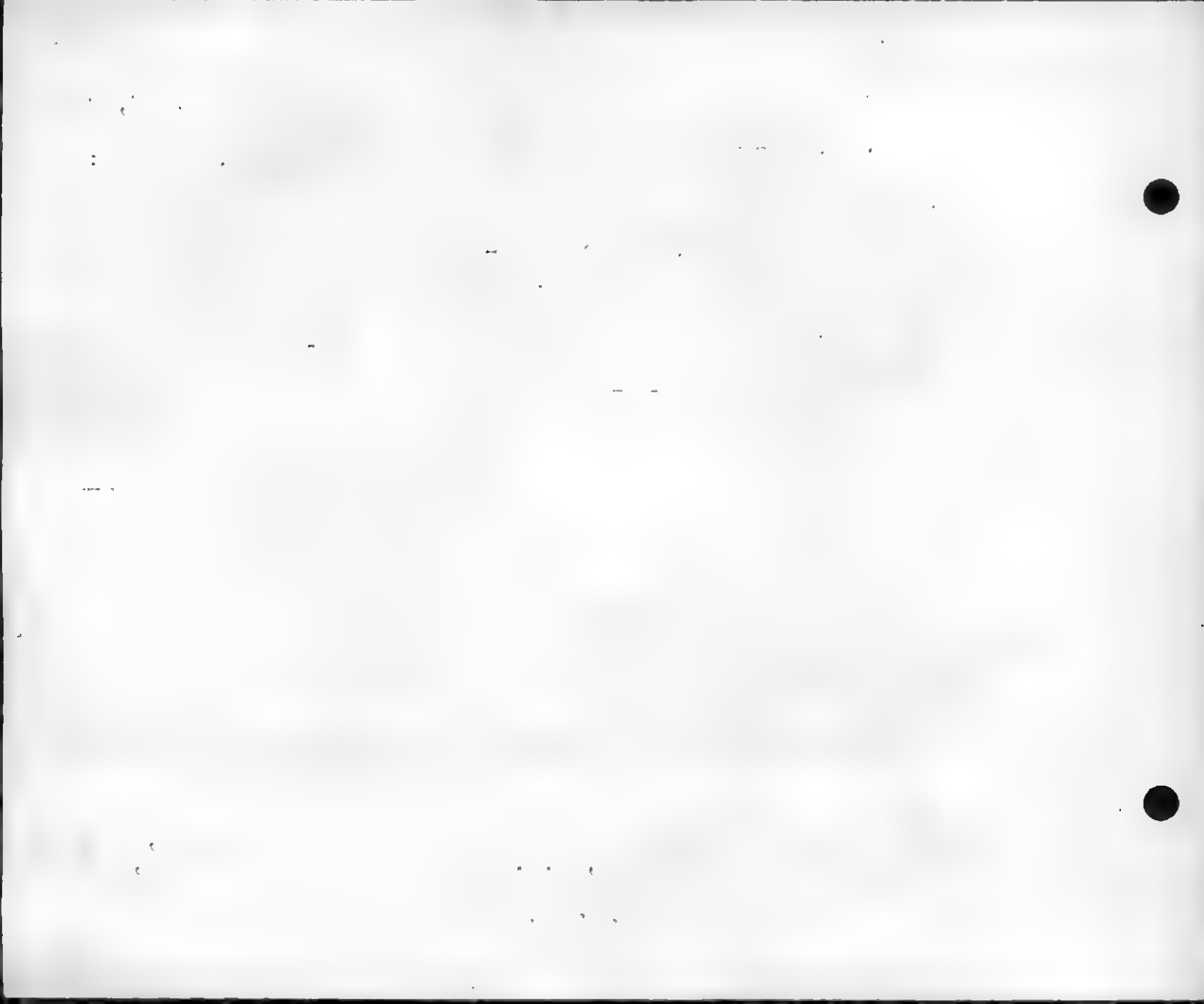
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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05014

05015

1. DECEASED NAME (Type or Print) <b>STEWART</b>		First		M. date		Last		2a. DATE KNOWN OF EST. DEATH MATED <b>APRIL 6, 1968</b>		2b. HOUR <b>9 A</b>	
3 SEX <b>MALE</b>	4 RACE <b>WHITE</b>	5. DATE OF BIRTH <b>3-3-1895</b>		6 AGE (In years last birthday) <b>73</b> YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.		2c. DATE PRONOUNCED DEAD Month Day Year <b>APRIL 6, 1968 9:00 A M</b>	
7a. BIRTHPLACE (State or foreign country) <b>SCOTLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH <b>ALLEGANY</b>					
10. CITY OR TOWN OF DEATH <b>CUMBERLAND</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>MEMORIAL HOSPITAL-DOA</b>				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>COMMUNITY BAKER</b>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) STATE <b>MARYLAND</b>		13b. COUNTY <b>ALLEGANY</b>		13c. CITY OR TOWN <b>CUMBERLAND</b>		3d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>506 VICTORIA STREET</b>			
14 FATHER'S NAME First <b>WILLIAM</b> Middle <b>REYNOLDS</b> Last <b>REYNOLDS</b>		15 MOTHER'S MAIDEN NAME First <b>ELIZABETH</b> Middle <b>STRACHIAN</b> Last <b>STRACHIAN</b>									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b>		16b. SOCIAL SECURITY NO <b>BRITISH ARMY 214-05-9681</b>		17. INFORMANT ADDRESS <b>MRS THURLA REYNOLDS 506 VICTORIA ST CUMBERLAND</b>							
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>109 CORONARY OCCLUSION</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last } (b) <b>CORONARY SCLEROSIS</b> DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>SUDDEN</b>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>420.1</b>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No		City or Town		County		State	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspect an <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <b>Benedict Skitarelic</b>		EXAMINER'S NAME (Type) <b>BENEDICT SKITARELIC, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>APRIL 6, 1968</b>	
23a. BURIAL CREMATION REMOVAL (Specify) <b>SOCIAL</b>		23b. DATE <b>APRIL 9, 1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>P.O.S. of A. CEMETERY</b>		23d. LOCATION (City or Town) (County) (State) <b>CENTREVILLE BLADFORD PA.</b>					
24. FUNERAL DIRECTOR <b>H. LEE SILCOX 404 DECATUR ST CUMBERLAND MD.</b>				25a. REC'D BY REGISTRAR <b>APR 9 - 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>					



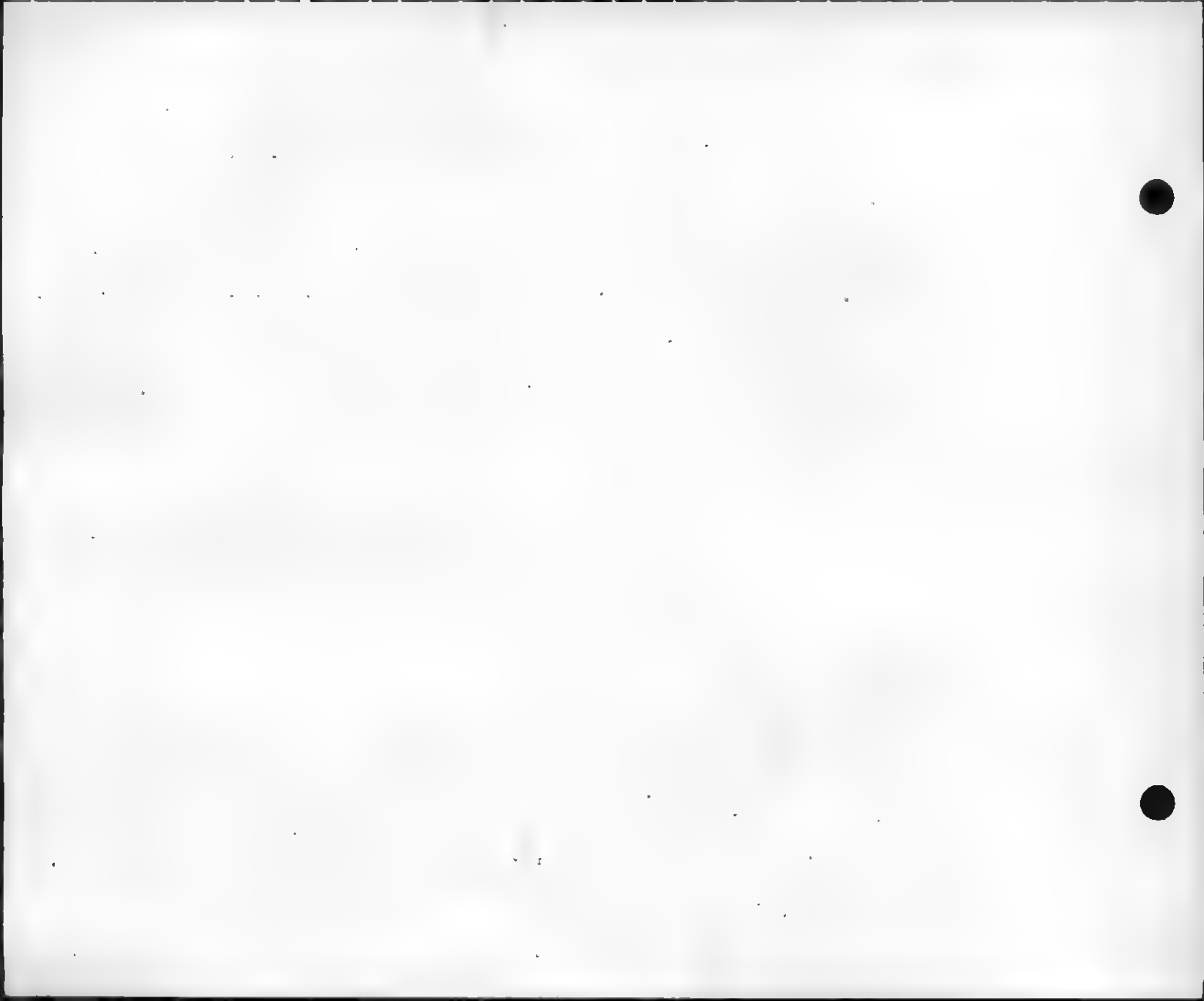
# FOR STATE HEALTH DEPT

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## MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. DECEASED NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF DEATH			Month Day Year			2b. HOUR			
Clarence Shaffer						Apr. 16 1968			10 A						
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (in years last birthday)	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN		2c. DATE PRONOUNCED DEAD			2d. HOUR				
Male	White	Feb. 11, 1905	65 YRS					Apr. 16 1968			10 A				
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9 COUNTY OF DEATH									
W. Va.		USA				Allegany Md.									
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY						
Cumberland			Memorial Hospital			Orderly			Hospital						
13a. USUAL RESIDENCE (Where deceased lived, if institution admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INS DE CITY LIMITS?			13e. STREET AND NUMBER			
Md.			Allegany			Cumberland			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			Y.M.C.A.-Baltimore Ave.			
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME												
First Middle Last			First Middle Last												
Nestor Shaffer			Belle Phillips												
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO			17 INFORMANT ADDRESS									
no						Roy K. Matthew, Wiley Ford, W.Va. Nephew									
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY OCCLUSION DUE TO, OR AS A CONSEQUENCE OF CORONARY THROMBOSIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) DUE TO, OR AS A CONSEQUENCE OF CORONARY SCLEROSIS (c) ----- APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH HOURS															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. ADJUSTED?							
								YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M.			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)									
			19												
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No.			City or Town			County		State	
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>															
ACTUAL SIGNATURE			CHIEF MEDICAL EXAMINER			ASSISTANT MEDICAL EXAMINER			22b. DATE SIGNED						
EXAMINER'S NAME (Type)			Dr. Benedict Skitarelic, M.D.			DEPUTY MEDICAL EXAMINER			April 16, 1968						
						ADDRESS (Street, city, town, or county)			Cumberland, Md.						
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town)			(County) (State)			
Burial			Apr. 19, 1968			Abe Cemetery			Cumberland, Allegany, Md.						
24. FUNERAL DIRECTOR						25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE						
James F. Scarpelli, Cumberland, Md.						DATE APR 18 1968			Charles Judge						



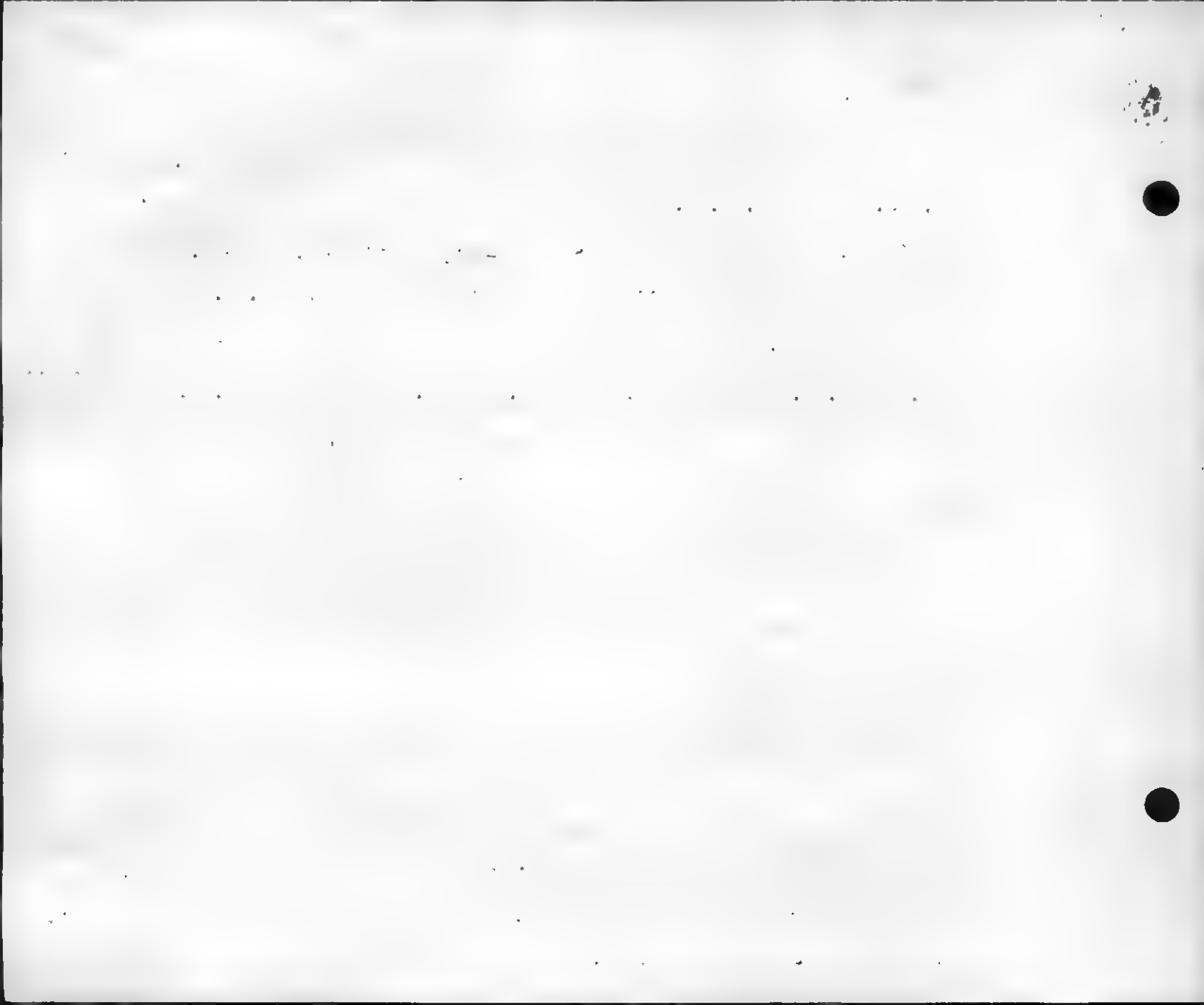
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## DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 DECEASED NAME (Type or Print) VERDUN WILLIAM SHAFER		First Middle Last		2a DATE KNOWN OF DEATH MAY 1, 1968		2b HOUR 2:50 PM	
3 SEX Male	4 RACE White	5 DATE OF BIRTH July 1, 1916	6 AGE (in years last birthday) 51 YRS	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN	2c DATE PRONOUNCED DEAD APRIL 30, 1968 2:50 PM	
7a BIRTHPLACE (State or foreign country) Va.	7b CITIZEN OF WHAT COUNTRY? U. S. A.	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Allegheny		12b KIND OF BUSINESS OR INDUSTRY Silk	
10. CITY OR TOWN OF DEATH Cumberland		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) MEMORIAL HOSPITAL-DOA		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Maintenance Supervisor		12b KIND OF BUSINESS OR INDUSTRY Silk	
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland		13b COUNTY Allegheny	13c CITY OR TOWN Cumberland	13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e STREET AND NUMBER 421 Ave. M. Potomac Park		
14. FATHER'S NAME William V. Shaffer		First Middle Last		15. MOTHER'S MAIDEN NAME Edith Winters		First Middle Last	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16b SOCIAL SECURITY NO 234-26-1071		17. INFORMANT ADDRESS Mrs. Lois M. Shaffer 421 Ave. M. Potomac Park			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4104 CORONARY OCCLUSION DUE TO, OR AS A CONSEQUENCE OF (b) CORONARY SCLEROSIS DUE TO, OR AS A CONSEQUENCE OF (c) Sudden							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH --
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 4201							
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED?		20 ALTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY Month, Day, Year 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f LOCATION Street or R.F.D. No		City or Town County State	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Benedict Skitarelic		EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b DATE SIGNED APRIL 30, 1968	
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE 5/3/68		23c NAME OF CEMETERY OR CREMATORY Sunset Memorial Park		23d LOCATION (City or Town) (County) (State) Cumberland, Allegheny, Md.	
24 FUNERAL DIRECTOR H. Wayne George Cumberland, Md.				25a RECEIVED BY REGISTRAR MAY 6 1968		25b REGISTRAR'S SIGNATURE Charles Judge	



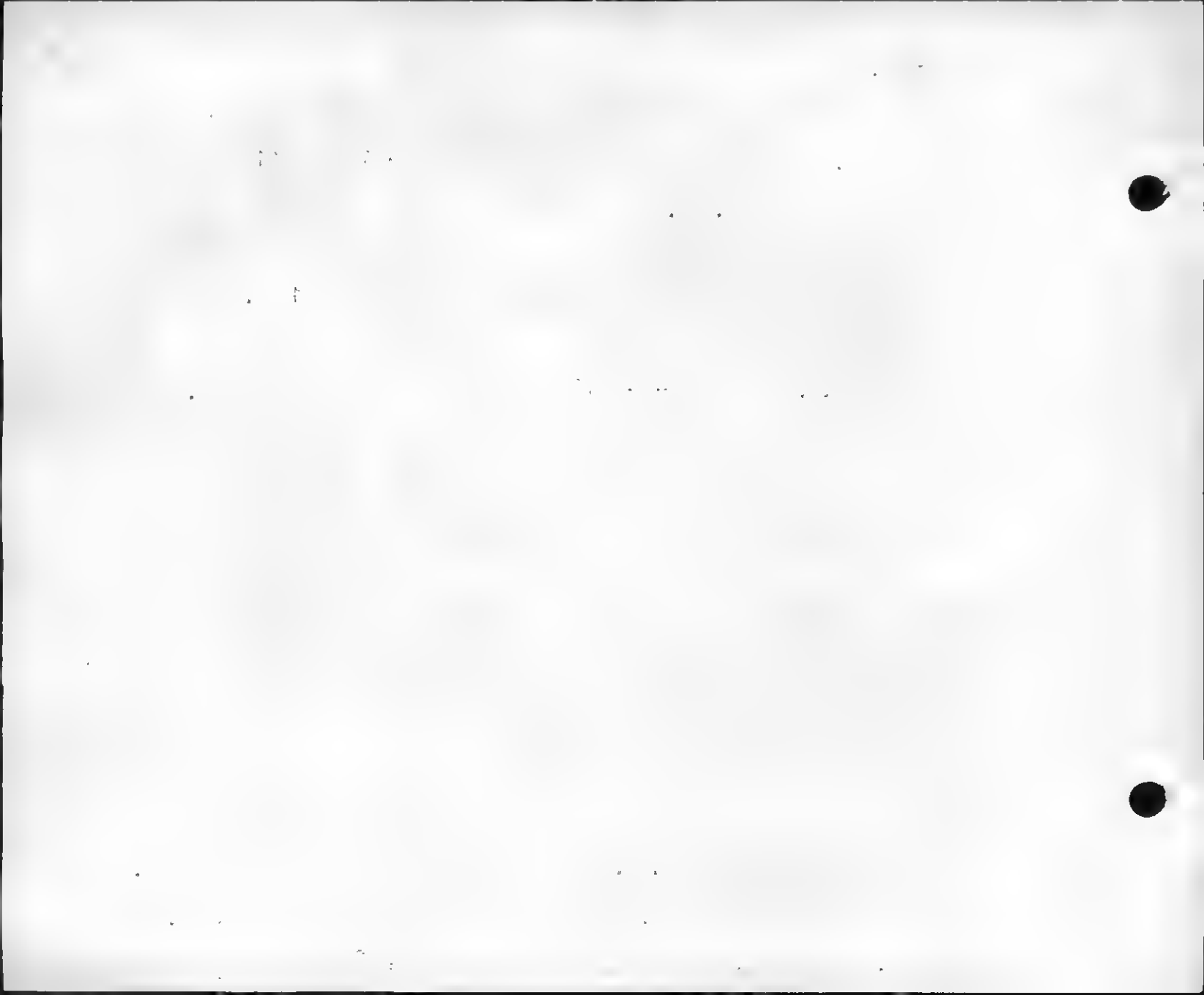
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 4 and 5, and return them to the funeral director, page 3 should be detached for use as the burial-transit permit, and in any event, within 72 hours after death, should be filed with the State Dept. of Health prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
**CERTIFICATE OF DEATH**

1 DECEASED NAME (Type or print) <b>LOUIS PATRICK SMITH</b>			2a. DATE OF DEATH Month <b>APRIL</b> Day <b>21</b> Year <b>1968</b>			2b. HOUR <b>M</b>				
3 SEX <b>MALE</b>		4 RACE <b>WHITE</b>		5. DATE OF BIRTH <b>MARCH 17, 1897</b>		6 AGE (In years last birthday) <b>71</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN		
7a. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>ALLEGANY</b> Md				
10. CITY OR TOWN OF DEATH <b>FROSTBURG</b>			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>MINERS HOSPITAL</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>RETIRED TAVERN OPERATOR</b>			12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) STATE <b>MARYLAND</b>			13b. COUNTY <b>ALLEGANY</b>		13c. CITY OR TOWN <b>FROSTBURG</b>		13d. INSIDE CITY LIMITS? <b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/>		13e. STREET AND NUMBER <b>113 E. MAIN STREET</b>	
14. FATHER'S NAME First Middle Last <b>LOUIS SMITH</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>ROSE ANN DRUM</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, army (known) (If yes give war or dates of service) <b>YES W.W. I</b>			16b. SOCIAL SECURITY NO <b>214-32-3216</b>		17 INFORMANT Address <b>EDWARD D. SMITH, MIDLAND, MD.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bilateral Lower - Pneumonia</b> <b>4/27</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Cardio-vascular - Disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>5 days -</b> <b>Years -</b>										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? <b>YES</b> <input type="checkbox"/> <b>NO</b> <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)			21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that <del>(I)</del> (this hospital) attended the deceased from <b>4/13</b> , 19 <b>68</b> , to <b>4/21</b> , 19 <b>68</b> , that (I) <del>(was)</del> last saw the deceased alive on <b>4/21/68</b> , 19 <b>68</b> , and that in (my) <del>(own)</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>(was)</del> <b>(did)</b> <del>(did not)</del> view the body after death.										
22b. SIGNATURE <b>John B. Davis</b> , DEGREE <b>ATTENDING PHYS</b> <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>						22c. DATE SIGNED <b>4/23/68</b>				
22d. PHYSICIAN'S NAME (Type) <b>JOHN B. DAVIS, M. D.</b>						22e. ADDRESS <b>2 BROADWAY, FROSTBURG, MD.</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>			23b. DATE <b>4-24-68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>ST. MICHAEL'S CEMETERY</b>			23d. LOCATION (City or Town) (County) (State) <b>FROSTBURG, MD.</b>		
24. FUNERAL DIRECTOR ADDRESS <b>JOSEPH R. DURST, SR., FROSTBURG, MD. 21532</b>						25a. REC'D BY REGISTRAR DATE <b>APR 25 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		

MEDICAL CERTIFICATION





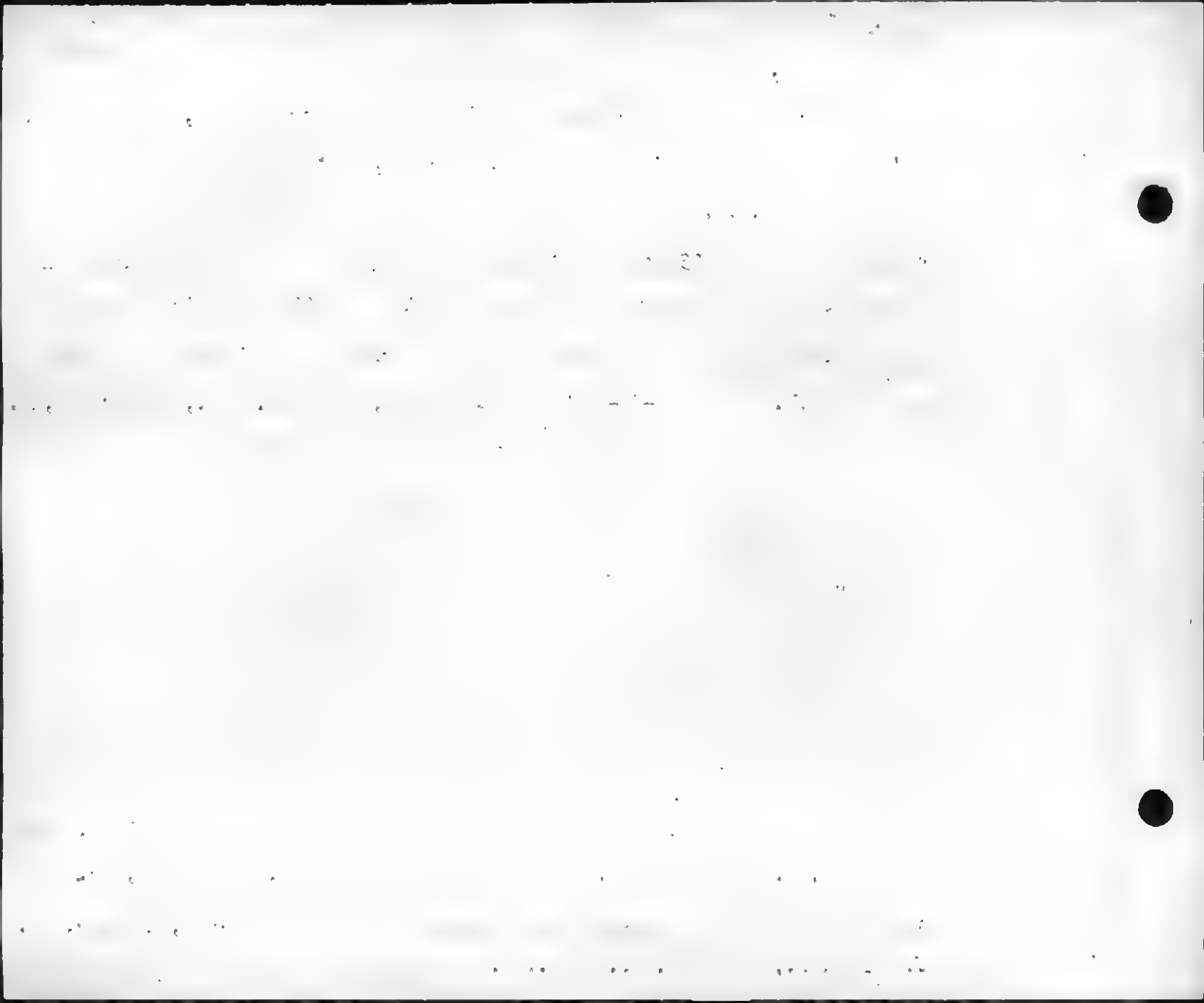
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15-14  
30M REV 1/68

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**  
**CERTIFICATE OF DEATH**

1 DECEASED-NAME (Type or print)		First	Middle	Last	2a DATE OF DEATH Month Day Year		2b HOUR	
		William	Lazarus	Smith	April 14, 1968		6 a M	
3. SEX	4 RACE		5 DATE OF BIRTH		6. AGE (In years lost birthday)		7. UNDER 1 YEAR MONTHS DAYS HOURS MIN	
Male	White		December 17, 1896		71 YRS.			
7a BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH		10. UNDER 24 HRS HOURS MIN	
Virginia	U.S.A.				Allegany Md			
10. CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b KIND OF BUSINESS OR INDUSTRY		
LaVale		923 Atlantic Avenue		Laborer		Construction		
13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER
Maryland		Allegany		LaVale				923 Atlantic Avenue
14. FATHER'S NAME First Middle Last			15 MOTHER'S MAIDEN NAME First Middle Last					
Peter Smith			Emily Susan See					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO.		17 INFORMANT Address				
Yes		W.W. I		217-10-5917 Curtis Smith, 119 Mass. Ave., Cumberland Md.				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Hypertension and Arteriosclerotic Heart Disease</i> <i>4120</i> DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <i>44-5</i> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>16 years</i>								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>Degenerative arthritis of spine and peripheral joints</i> <i>Parkinsonism</i>								
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. If YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
3/4/68		epigastric hernia						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21a. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State
22a I certify that (I) (this hospital) attended the deceased from <i>12/17</i> , 19 <i>67</i> , to <i>4/14</i> , 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>4/14</i> , 19 <i>68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <i>S. G. Weisman</i>						22c. DATE SIGNED April 15, 1968		
22d. PHYSICIAN'S NAME (Type) S. G. Weisman, M.D.						22e. ADDRESS 59 Greene Street, Cumberland, Md.		
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)		
Burial		4/17/68		Sunset Memorial Park		Near Cumberland, Allegany, Md.		
24 FUNERAL DIRECTOR John J. Hafer, Jr., 280 Balto. Ave., Cumb., Md.				25a. REC'D BY REGISTRAR DATE APR 17 1968		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		



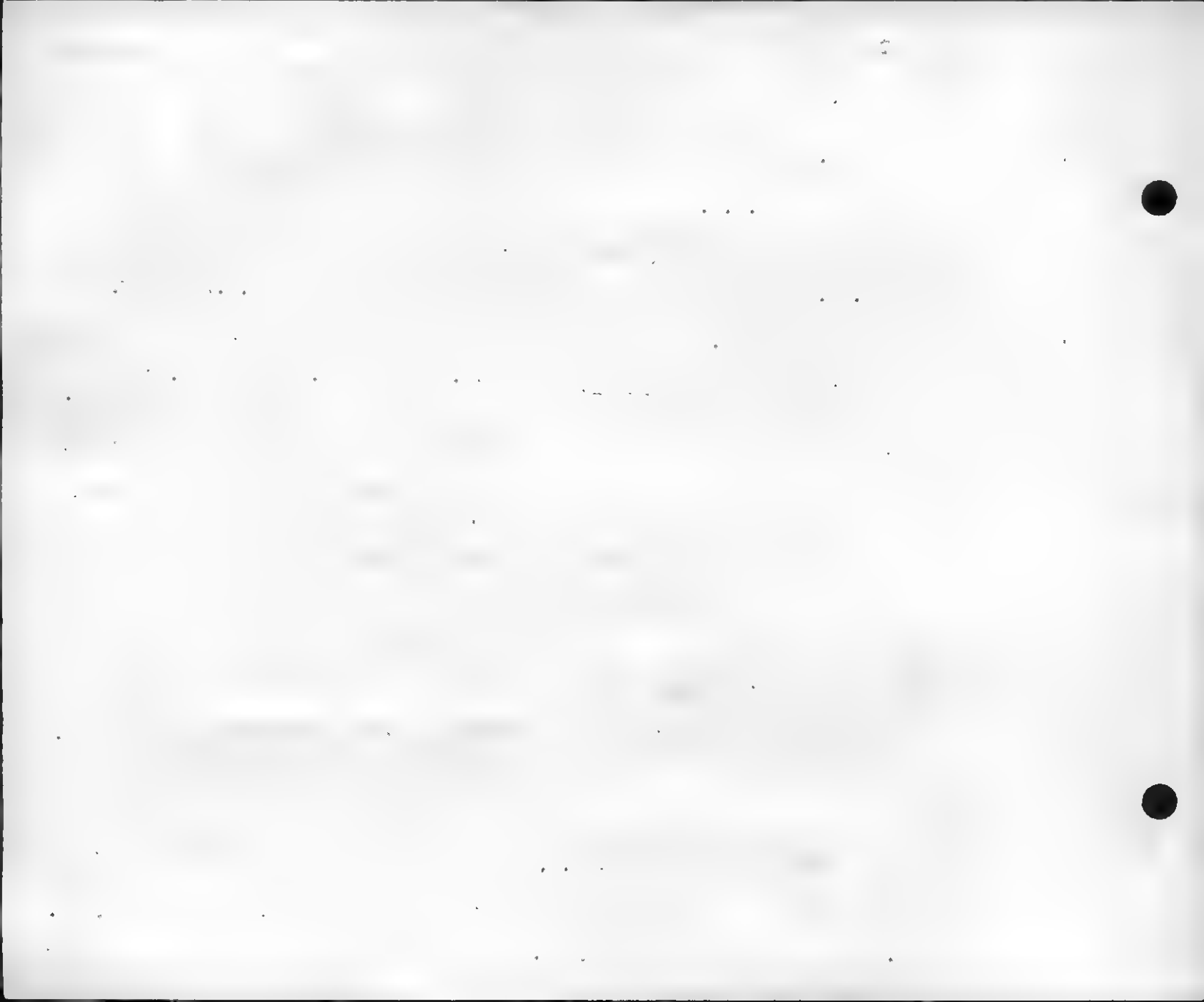
**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-1. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

**TO DEPUTY MEDICAL EXAMINER:** If necessary, please execute the certificate of death for the deceased and forward it to the funeral director. Page 4 should be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be retained for your files. Health prior to burial, cremation

CHIEF MEDICAL EXAMINER ☐ 22b DATE SIGNED  
ASSISTANT MEDICAL EXAMINER ☐  
DEPUTY MEDICAL EXAMINER ☒ APRIL 21, 1968  
ADDRESS (Street, city, town, or county) CUMBERLAND, MARYLAND

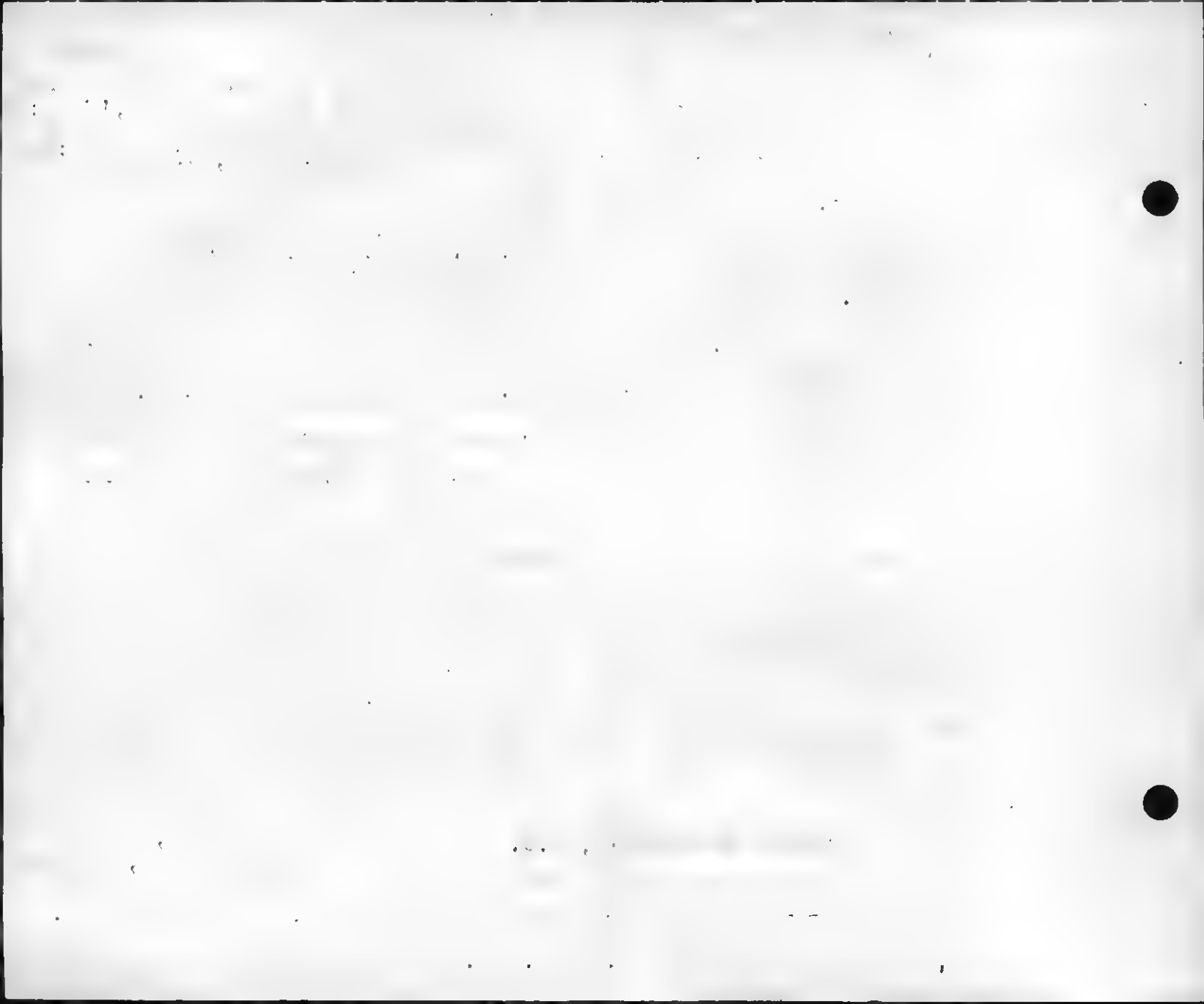


# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1 DECEASED NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF DEATH			2b. HOUR
Stewart Bryan Stinson						MAY 1, 1968			4:00 PM
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN.	2c. DATE PRONOUNCED DEAD			2d. HOUR
Male	White	4-5-1910	57 YRS			April 1, 1968			4:00 PM
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Arvonia, Va.		USA				Allegany			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY
Flintstone			Flintstone, Md.			Building Contractor			Contractor
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
Md.			Allegany			Flintstone			
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
First Middle Last			First Middle Last						
John T. Stinson			Ida Maxey						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO			17. INFORMANT ADDRESS			
No			226-18-4230			Mrs. Ivy Stinson Flintstone, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b>									<b>Sudden</b>
DUE TO, OR AS A CONSEQUENCE OF <b>Coronary Sclerosis</b>									--
CONDITIONS if any, which gave rise to immediate cause (a) stating the underlying cause last.									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M.			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE			CHIEF MEDICAL EXAMINER			22b. DATE SIGNED			
Benedict Skitarelic			BENEDICT SKITARELIC, M.D.			April 1, 1968			
EXAMINER'S NAME (Type)			DEPUTY MEDICAL EXAMINER			ADDRESS (Street, city, town, or county)			
			Richmond			Henrico Va.			
23a. BURIAL CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)
Burial			4-4-68			Oakwood Cemetery			Richmond Henrico Va.
24. FUNERAL DIRECTOR			25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE			
H. Lee Silcox			404 Decatur St., Cumb., Md.			APR 4 1968			



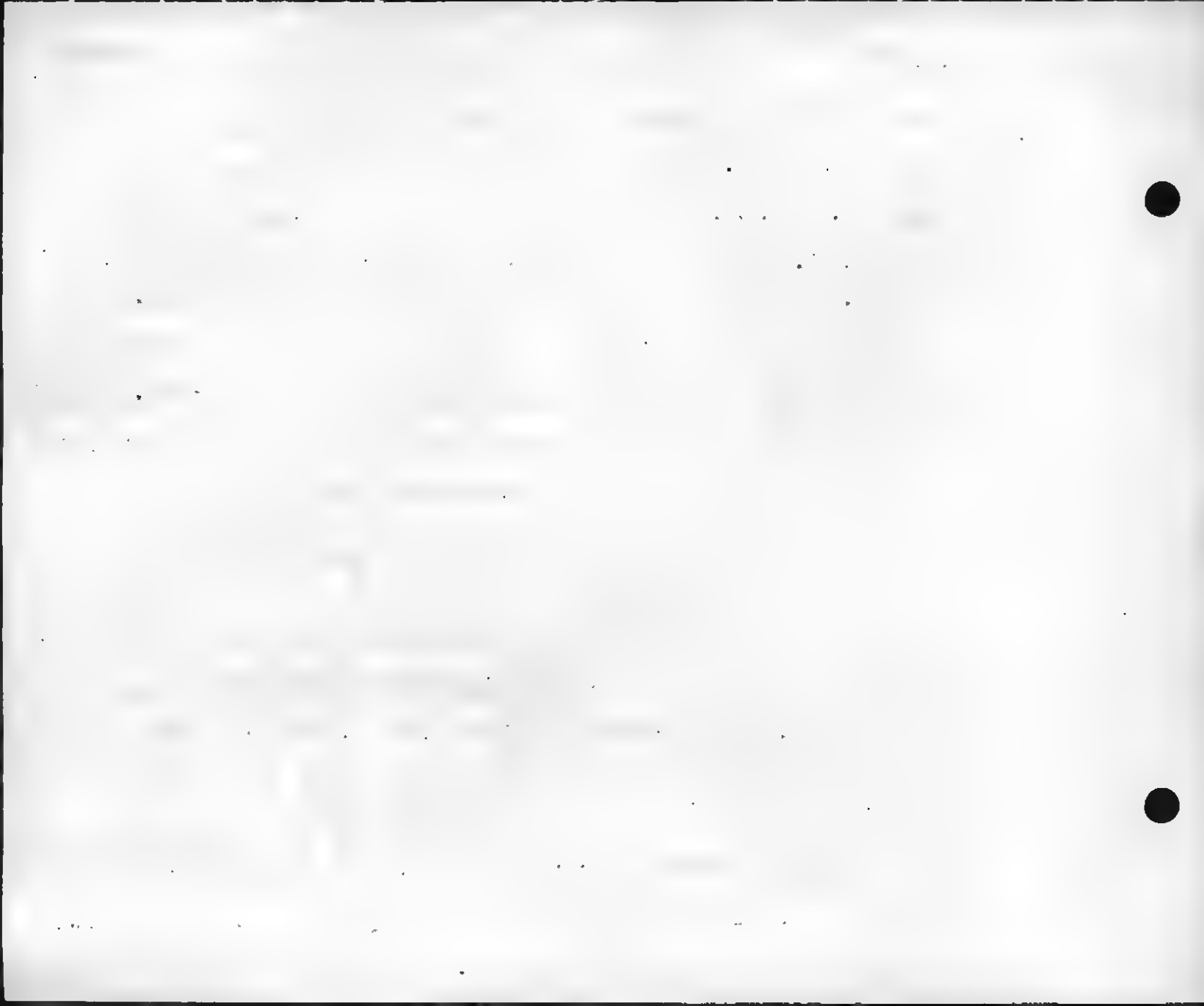
FOR STATE  
HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 DECEASED NAME (Type or Print) <b>ROBERT</b>		First Middle Last <b>CHARLES TILBERG</b>		2a DATE KNOWN OF DEATH Month Day Year <b>APRIL 21, 1968</b>		2b HOUR p 9:25	
3 SEX <b>MALE</b>	4 RACE <b>WHITE</b>	5 DATE OF BIRTH <b>NOV. 1, 1939</b>	6 AGE (in years last birthday) <b>28</b> YRS	7 UNDER 1 YEAR MONTHS DAYS HOURS MIN		8 UNDER 24 HRS HOURS MIN	
7a BIRTHPLACE (State or foreign country) <b>EMPORIUM, PA.</b>		7b CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH <b>ALLEGANY</b>	
10 CITY OR TOWN OF DEATH <b>CUMBERLAND, MD.</b>		11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) <b>MEMORIAL HOSPITAL</b>		12a USUAL OCCUPATION (Kind of work done during most of working life even if retired) <b>LABORER</b>		12b KIND OF BUSINESS OR INDUSTRY <b>CONSTRUCTION</b>	
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <b>MD.</b>		13b COUNTY <b>1</b>		13c CITY OR TOWN <b>HYATSVILLE</b>		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME First Middle Last <b>GEORGE TILBERG</b>		15 MOTHER'S MAIDEN NAME First Middle Last <b>ELLEN HARPSTER TILBERG</b>		16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b> <b>NAVY</b>			
16b SOCIAL SECURITY NO		17 INFORMANT ADDRESS <b>GEORGE TILBERG EMPORIUM PENNA.</b>					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>CRUSHED CHEST</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>(AUTOMOBILE ACCIDENT)</b> DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY Month, Day, Year HOUR AM <b>9:25 PM April 21, 1968</b>		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) <b>DRIVER IN TWO CAR COLLISION</b>			
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <b>RT. #40, two miles west of ELINTSTONE, ALLEGANY, MARYLAND</b>		21f LOCATION Street or R.F.D. No. City or Town County State			
22a I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <i>Benedict Skitarelic</i> EXAMINER'S NAME (Type) <b>BENEDICT SKITARELIC, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		22b DATE SIGNED <b>APRIL 21, 1968</b>	
23a BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b DATE <b>4 25 1968</b>		23c NAME OF CEMETERY OR CREMATORY <b>NEWTON CEMETERY</b>		23d LOCATION (City or Town) (County) (State) <b>EMPORIUM, PENNA.</b>	
24 FUNERAL DIRECTOR ADDRESS <b>COPPERSMITH FUNERAL HOME EMPORIUM, PENNA.</b>		25a REC'D BY REGISTRAR <b>APR 23 1968</b>		25b REGISTRAR'S SIGNATURE <i>John J. Smith</i>			





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<div style="text-align: center;"> <b>MARYLAND STATE DEPARTMENT OF HEALTH</b>  <b>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</b>  <b>CERTIFICATE OF DEATH</b> </div>													
1. DECEASED NAME (Type or print)			First		Middle		Last		2a. DATE OF DEATH			2b. HOUR	
XXX ERNEST			B.				TREAT		4 Month 20 Day 68 Year			10:47	
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (In years last birthday)			IF UNDER 1 YEAR MONTHS DAYS	
MALE			WHITE			7-30-09			58 YRS.			IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH			Md.	
PENNA.			U.S.A.						ALLEGANY				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY				
CUMBERLAND, MD.			SACRED HEART HOSPITAL			INN MANAGER			INN				
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER	
MD.			ALLEGANY			CUMBERLAND			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			704 PIEDMONT AVE.	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME										
JESSE			TREAT			ELIZABETH			ANN			BOSARD	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO.			17. INFORMANT			Address				
Yes			208-09-9755			SACRED HEART HOSP.			CUMBERLAND, MD.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral aneurysm - Hypertension</u>												3 years	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last <u>445</u>												5 years	
(b) <u>Hypertension, Essential + Arteriosclerosis</u>													
(c)													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)													
<u>Cerebral aneurysm, left internal carotid artery</u>													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 Item 18.)							
21a. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21a. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from <u>1960</u> to <u>April 20, 1968</u> , that (I) (we) last saw the deceased alive on <u>4/20</u> 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE			22c. DATE SIGNED										
<u>Dr. Weisman</u>			<u>MD</u>			<u>4/22/68</u>							
22d. PHYSICIAN'S NAME (Type)			22e. ADDRESS										
DR. WEISMAN			<u>Cumberland, Md.</u>										
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)				
Burial			23 Apr 68			Hillcrest Burial Park			Cumberland Allegany Md.				
24. FUNERAL DIRECTOR			ADDRESS			25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE				
SILCOX FUNERAL HOME, CUMBERLAND, MD.						DATE			<u>APR 24 1968</u>			<u>Charles Judge</u>	

V C J

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1 DECEASED-NAME (Type or print) GEORGE			First V. Middle TREXLER Last			2a DATE OF DEATH 04 Month 18 Day 68 Year		2b HOUR 0630M		
3 SEX MALE		4 RACE WHITE		5 DATE OF BIRTH 01-14-92		6 AGE (in years last birthday) 76 YRS.		IF UNDER 1 YEAR MONTHS DAYS		
7a BIRTHPLACE (State or foreign country) W. VIRGINIA		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH ALLEGANY COUNTY, Md				
10 CITY OR TOWN OF DEATH CUMBERLAND			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) SACRED HEART HOSPITAL			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY		
13a USUAL RESIDENCE (Where deceased lived if institution. Residence before admission) STATE MARYLAND			13b COUNTY ALLEGANY		13c CITY OR TOWN CUMBERLAND		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER 509 CENTRAL AVENUE	
14 FATHER'S NAME GRANT			First Middle Last TREXLER			15 MOTHER'S MAIDEN NAME WENDAL, ALICE			First Middle Last TREXLER	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service)			16b SOCIAL SECURITY NO 220-32-4922		17 INFORMANT HOSPITAL RECORDS-CUMBERLAND, MD. 21502			Address 900 SETON DR.		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										
PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RIGHT VENTRICULAR FAILURE										
DUE TO, OR AS A CONSEQUENCE OF (b) COR PULMONALE										
DUE TO, OR AS A CONSEQUENCE OF (c) FIBROSIS FOLLOWING TUBERCULOSIS										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Port 2, Item 18.)					
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f LOCATION Street or R.F.D. No.		City or Town		County State	
22a I certify that (I) (this hospital) attended the deceased from 8 - 12, 1954, to 4 - 18, 1968, that (I) (we) last saw the deceased alive on 4 - 17, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b SIGNATURE R. W. Ballin							22c DATE SIGNED 4-18-68			
22d PHYSICIAN'S NAME (Type) DR. R. W. BALLIN					22e ADDRESS 62 GREENE ST., CUMB., MD. 21502					
23a BURIAL CREMATION, REMOVAL (Specify) Burial		23b DATE April 21, 1968		23c NAME OF CEMETERY OR CREMATORY Olivet Cemetery		23d LOCATION (City or Town) Moorefield		(County) (State) W. Va.		
24 FUNERAL DIRECTOR WENDT FUNERAL HOME-121 MEMORIAL AVE., CUMB.,					25a REC'D BY REGISTRAR APR 24 1968		25b REGISTRAR'S SIGNATURE Charles Yunge			

1. The first part of the report is a general  
introduction to the subject of the study.  
It is a very important part of the report  
and should be written in a clear and concise  
manner.

2. The second part of the report is a  
detailed description of the methods used in  
the study. This part should be written in a  
clear and concise manner and should include  
a description of the subjects, the materials,  
and the procedures used.

3. The third part of the report is a  
discussion of the results of the study. This  
part should be written in a clear and concise  
manner and should include a description of  
the results, a comparison of the results with  
previous studies, and a discussion of the  
implications of the results.

4. The fourth part of the report is a  
conclusion. This part should be written in a  
clear and concise manner and should include  
a summary of the findings of the study and  
a statement of the conclusions drawn from the  
study.

5. The fifth part of the report is a  
list of references. This part should be  
written in a clear and concise manner and  
should include a list of all the sources  
used in the study.

6. The sixth part of the report is an  
appendix. This part should be written in a  
clear and concise manner and should include  
any additional information that is relevant  
to the study.

# FOR STATE HEALTH DEPT.

1. This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Pages 5 may be retained for your files.

2. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 DECEASED-NAME (Type or Print) <b>George McClellan Twigg</b>		2a DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month <input checked="" type="checkbox"/> Day <input checked="" type="checkbox"/> Year <b>APRIL 17, 1968</b>		2b HOUR <b>1 P.M.</b>
3 SEX <b>Male</b>	4 RACE <b>White</b>	5 DATE OF BIRTH <b>9/25/06</b>	6 AGE (In years last birthday) <b>61</b> YRS	7c DATE PRONOUNCED DEAD <b>APRIL 17, 1968</b>
7a BIRTHPLACE (State or foreign country) <b>Maryland</b>		7b CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
9 COUNTY OF DEATH <b>Allegany</b>		9d CITY OR TOWN OF DEATH <b>Cumberland</b>		
10 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>MEMORIAL HOSPITAL-DOA</b>		11 USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Linoleum</b>		12b KIND OF BUSINESS OR INDUSTRY <b>Construction</b>
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <b>Maryland</b>		13b COUNTY <b>Allegany</b>	13c CITY OR TOWN <b>Cumberland</b>	13d INSIDE CITY, YARDS? <b>YES</b> <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14 FATHER'S NAME First <b>John</b> Middle <b>H.</b> Last <b>Twigg</b>		15 MOTHER'S MAIDEN NAME First <b>Isabella</b> Middle <b>Klipsstein</b> Last <b>Klipsstein</b>		
16a WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16b SOCIAL SECURITY NO <b>214-05-8591</b>		17 INFORMANT <b>Mr. Francis E. Twigg P. O. Box # 434</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>BRONCHOGENIC CARCINOMA</b> DUE TO, OR AS A CONSEQUENCE OF <b>WITH GENERALIZED METASTASIS</b> (b) <b>MONTHS</b> DUE TO, OR AS A CONSEQUENCE OF (c)				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>16.11</b>				
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED?		20 ALTOPSY? <b>YES</b> <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY Month, Day, Year <b>19</b>		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK		21e PLACE OF INJURY (At home, farm street, factory, office building, etc.)		21f LOCATION Street or R.F.D. No City or Town County State
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>				
ACTUAL SIGNATURE <b>Benedict Skitarelic</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type) <b>BENEDICT SKITARELIC, M.D.D</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE <b>4/20/68</b>		
23c NAME OF CEMETERY OR CREMATORY <b>Hillcrest Burial Park</b>		23d LOCATION (City or Town) (County) (State) <b>Cumberland, Allegany Md.</b>		
24 FUNERAL DIRECTOR <b>H. agro George Cumberland, Md.</b>		ADDRESS		
25a REC'D BY REGISTRAR <b>APR 22 1968</b>		25b REGISTRAR'S SIGNATURE <b>Charles Judge</b>		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

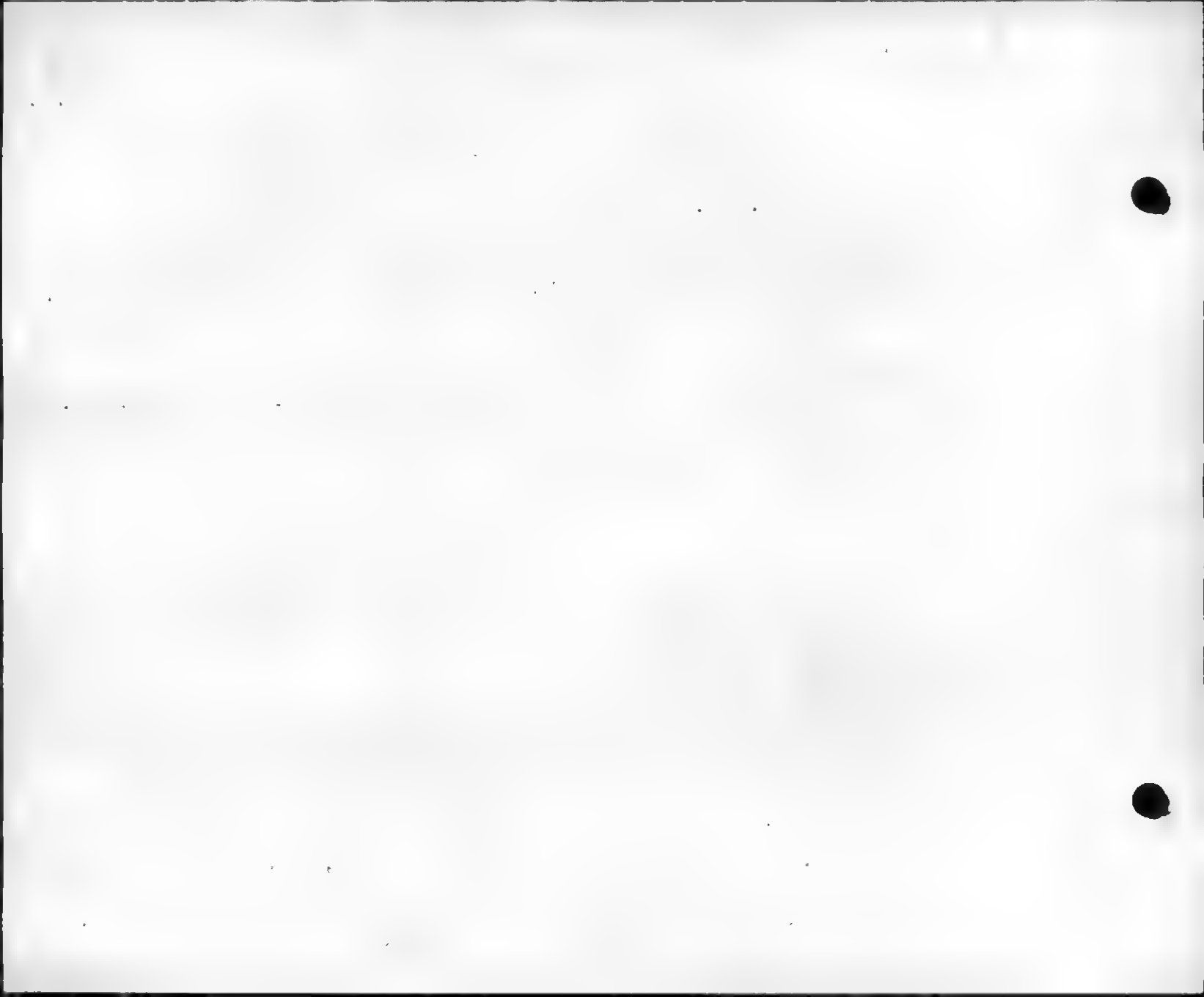
**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**

15025

**CERTIFICATE OF DEATH**

05096

1. DECEASED NAME (Type or print) <b>First</b> <b>KNOVA</b> <b>Middle</b> <b>TWIGG</b> <b>Last</b>			2a. DATE OF DEATH Month <b>APRIL</b> Day <b>22</b> Year <b>1968</b>			2b. HOJR <b>P.M.</b> <b>3:20</b>	
3. SEX <b>MALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH <b>8-4-09</b>		6. AGE (In years last birthday) <b>58</b> YRS.	
7a. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>ALLEGANY</b> Md.	
10. CITY OR TOWN OF DEATH <b>CUMBERLAND</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>MEMORIAL HOSPITAL</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>SELF EMPLOYED</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MARYLAND</b>		13b. COUNTY <b>ALLEGANY</b>		13c. CITY OR TOWN <b>CUMBERLAND</b>		13d. INSIDE CITY (Y.N.T.S.) <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER <b>1303 LAFAYETTE AVE.</b>		14. FATHER'S NAME <b>First</b> <b>ASHBY</b> <b>Middle</b> <b>TWIGG</b> <b>Last</b>		15. MOTHER'S MAIDEN NAME <b>First</b> <b>FLORIDA</b> <b>Middle</b> <b>SIRYROCK</b> <b>Last</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown] <b>NO</b> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO		17. INFORMANT <b>MEMORIAL HOSPITAL, CUMBERLAND, MD</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Myocarditis &amp; Decomposition</b> <b>108X</b> DUE TO, OR AS A CONSEQUENCE OF <b>trauma</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF _____ (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>6 mos</b> <b>6 wks</b>							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) <b>222</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. _____ Month _____ Day _____ Year <b>19</b> P.M. _____		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No _____ City or Town _____ County _____ State _____			
22a. I certify that (I) (this hospital) attended the deceased from <b>Feb 1, 1968</b> to <b>Apr 22, 1968</b> , that (I) (we) last saw the deceased alive on <b>Apr 22, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Clay Durrett</b>		22c. PHYSICIAN'S NAME (Type) <b>DR. CLAY DURRETT</b>		22d. ADDRESS <b>CUMBERLAND, MD.</b>		22e. DATE SIGNED <b>Apr. 24, 1968</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>Apr. 25, 1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Oldtown Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Oldtown, Allegany, Md.</b>	
24. FUNERAL DIRECTOR <b>JAMES F. SCARONELLI, Cumberland, Md.</b>				25a. REC'D BY REGISTRAR DATE <b>Apr 29 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



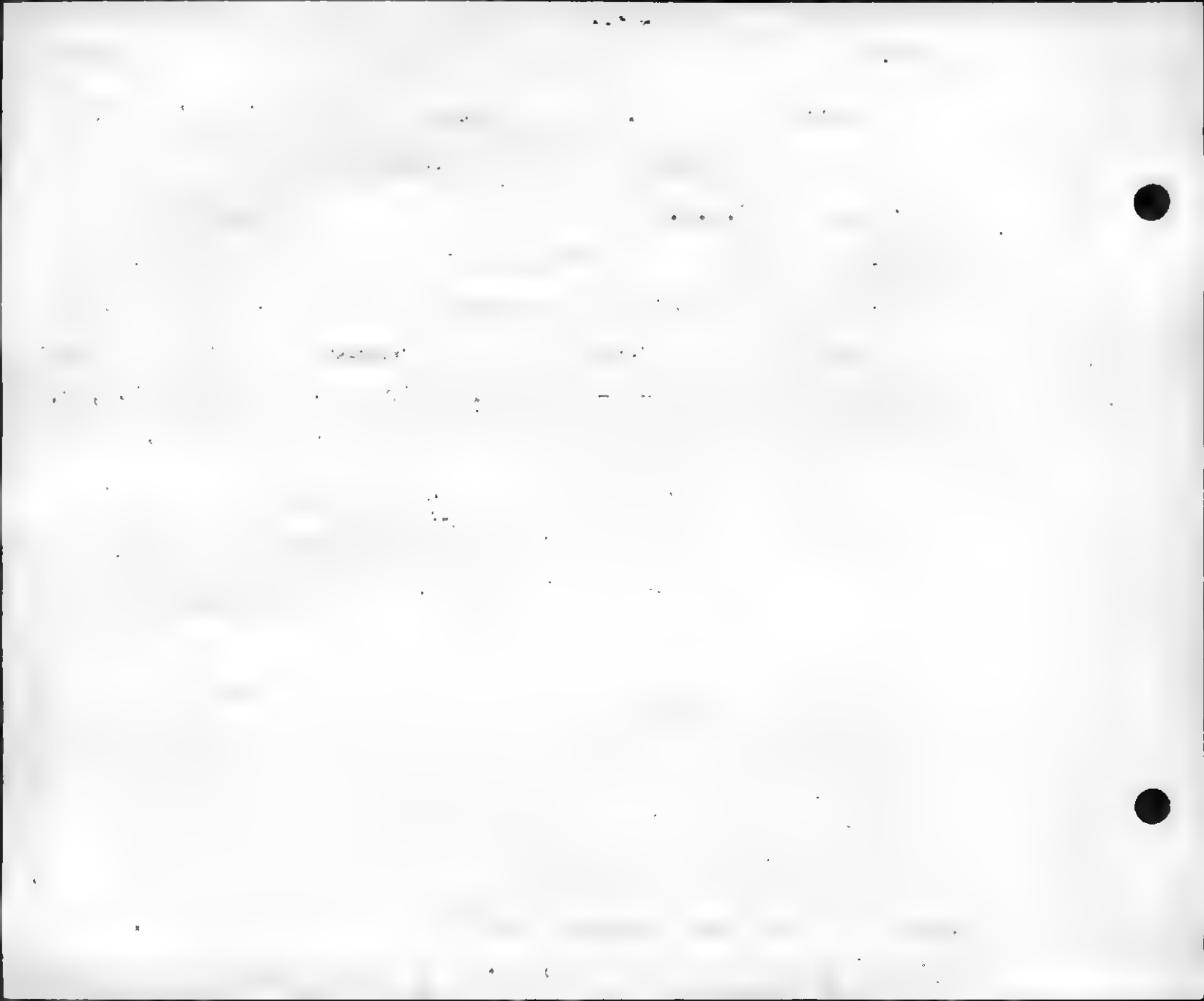


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VR A15 (4)  
30M REV 1/68

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH		2b. HOUR	
Harry R. Uphold						Month	Day	Year	M
3 SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR	
Male		White		6/14/1888		79 YRS		MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Maryland		U.S.A.				Allegany Md			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY			
Lonaconing		Detmold Street		Retired Miner		Coal Mine			
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER	
Md		Allegany		Lonaconing				Detmold Street	
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First Middle Last
James Uphold						Ctoma May Tasker			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO		17. INFORMANT		Address			
		220-03-7083		Mrs. Bessie Uphold		Lonaconing, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4109 Acute Coronary Occlusion DUE TO, OR AS A CONSEQUENCE OF (b) Coronary Insufficiency DUE TO, OR AS A CONSEQUENCE OF (c) Generalized Arteriosclerosis								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
								immediate years years	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Chronic Pulmonary Fibrosis									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from 1960, to 4-17, 1968, that (I) (we) lost saw the deceased alive on 4-15, 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE		DEGREE		ATTENDING PHYS.		MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED	
L.R. MILES, JR., M.D.								4-18-68	
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS							
L.R. MILES, JR., M.D.		LONA CONING MD 21539							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County) (State)	
Burial		4/19/68		Memorial Park		Frostburg A.		Md	
24. FUNERAL DIRECTOR				ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
George Eichhorn				Lonaconing, Md.		DATE		APR 19 1968	



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

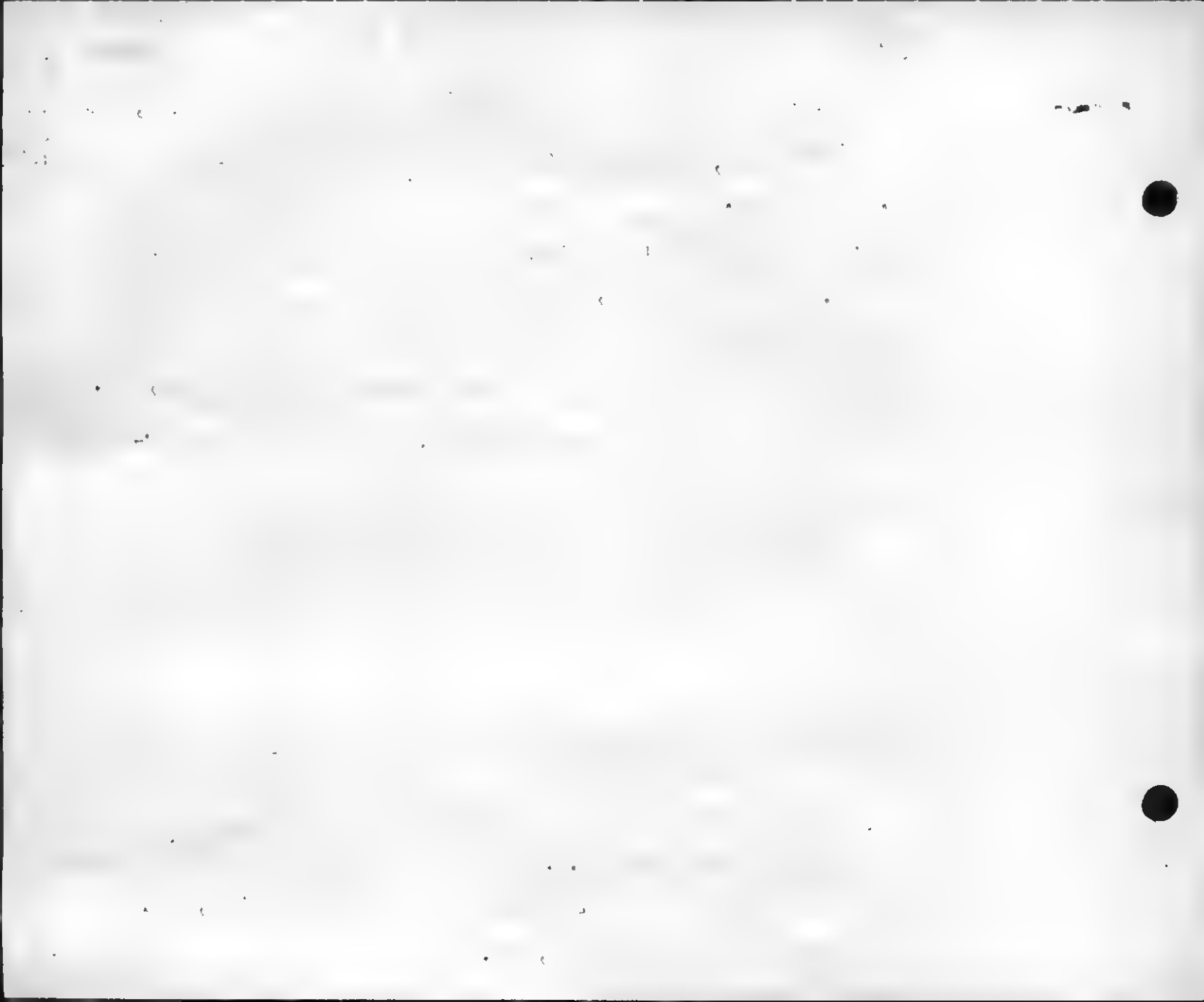
TO FUNERAL DIRECTOR: Page 3 should be used on burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
10M REV. 1/68

05027

## DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 DECEASED NAME (Type or Print) <b>James Waddell</b>			2a DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/> <b>APRIL 7, 1968</b>			2b HOUR <b>12:15</b>		
3 SEX <b>Male</b>	4 RACE <b>White</b>	5 DATE OF BIRTH <b>Nov. 10th/1900</b>	6 AGE (in years last birthday) <b>67</b>	7 UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b>	IF UNDER 24 HRS HOURS <b>0</b> MIN <b>0</b>	2c DATE PRONOUNCED DEAD Month <b>APRIL</b> Day <b>7</b> Year <b>1968</b>		
7a BIRTHPLACE (State or foreign country) <b>MD.</b>		7b CITIZEN OF WHAT COUNTRY? <b>USA.</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH <b>Allegany</b>		
10 CITY OR TOWN OF DEATH <b>Frostburg</b>			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Miner's Hospital</b>			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b KIND OF BUSINESS OR INDUSTRY
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <b>MD.</b>			13b COUNTY <b>Allegany, Lonaconing</b>		13c CITY OR TOWN <b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/>	13d STREET AND NUMBER		
4 FATHER'S NAME First <b>Douglas</b> Middle <b>Waddell</b> Last <b></b>			15 MOTHER'S MAIDEN NAME First <b>Margaret</b> Middle <b>Mason</b> Last <b></b>					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes no or unknown) <b>NO</b>			16b. SOCIAL SECURITY NO.		17. INFORMANT <b>Ruth Waddell</b> ADDRESS <b>Lonaconing, Md. (Sister)</b>			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>LOBAR PNEUMONIA, RIGHT</b> <b>481X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b></b> (c) <b></b> DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2-3 DAYS</b>								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (c) <b></b>								
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? <b>YES</b> <input type="checkbox"/> <b>NO</b> <input type="checkbox"/>		
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b TIME OF INJURY Month Day, Year HOUR A.M. <b>19</b> P.M. <b></b>		21c HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18)			
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f LOCATION Street or R.F.D. No City or Town County State			
22a I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE <b>Benedict Skitarellic</b> EXAMINER'S NAME (Type) <b>BENEDICT SKITARELIC, M.D.</b>			CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ADDRESS (Street, city, town, or county) <b>Cumberland, Maryland</b>			22b DATE SIGNED <b>APRIL 7, 1968</b>		
23a BURIAL, CREMATION REMOVAL (Specify)		23b DATE <b>4/9/1968</b>		23c NAME OF CEMETERY OR CREMATORY <b>Oak Hill Cemetery</b>		23d LOCATION (City or Town) (County) (State) <b>Lonaconing, Md.</b>		
24 FUNERAL DIRECTOR <b>George Eichhorn</b>			ADDRESS <b>Lonaconing, Md.</b>			25a REC'D BY REGISTRAR <b>APR 10 1968</b>		25b REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>



FOR STATE  
HEALTH DEPT.

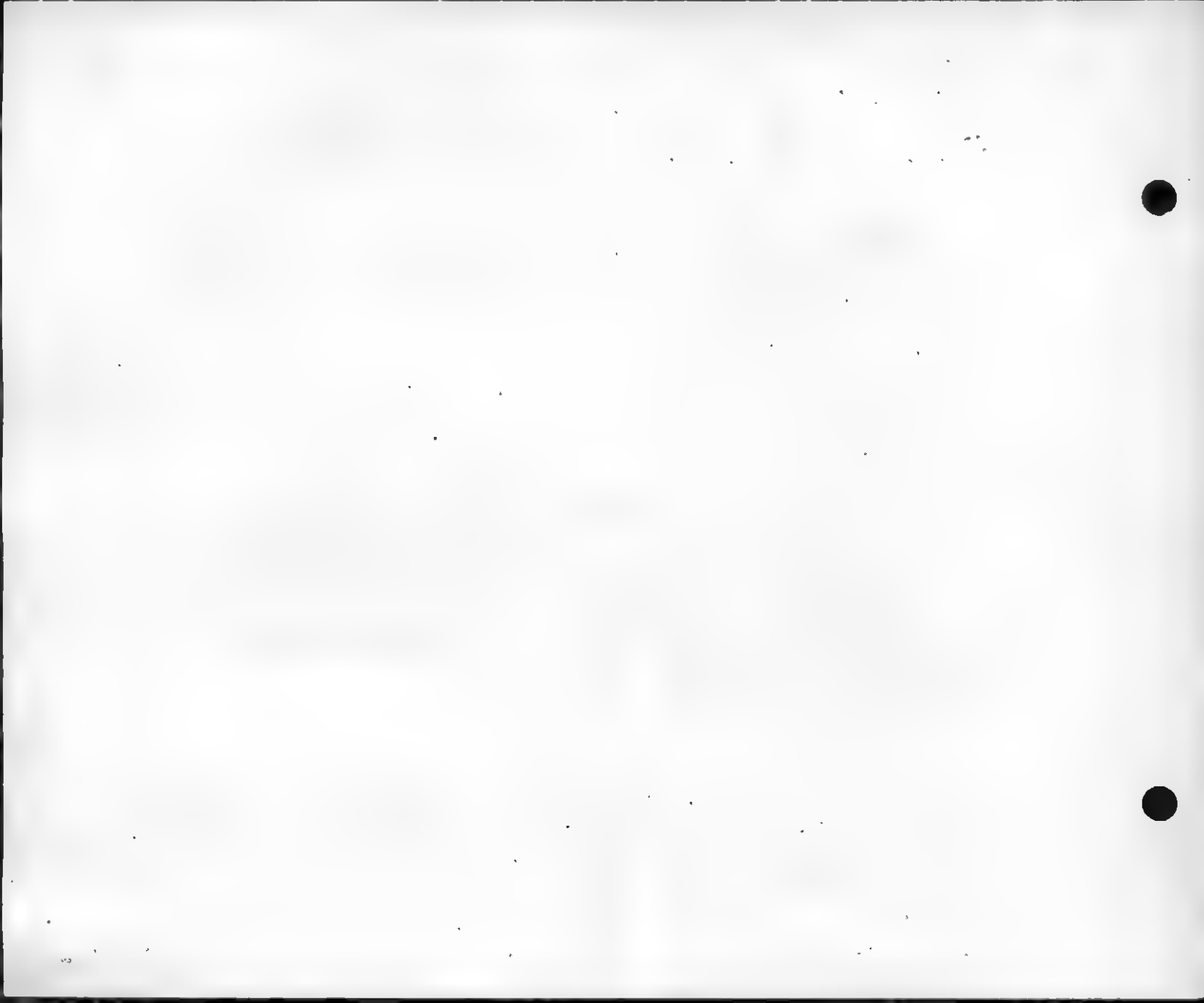
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

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05026

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 DECEASED NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF DEATH			2b. HOUR		
Emma			L. Walker			Month Day Year			4:15 PM		
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (in years last birthday)	7 UNDER 1 YEAR		8 IF UNDER 24 HRS		2c. DATE PRONOUNCED DEAD			2d. HOUR
Female	White	Nov. 27, 1892	75 YRS	MONTHS	DAYS	HOURS	MIN	Month Day Year			4:15 PM
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9 COUNTY OF DEATH		
Maryland			USA						Allegany Md		
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY		
Cumberland			D.O.A. Memorial Hospital			housewife			Own Home		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
Md.			Allegany			Cumberland			Mexico Farms		
14 FATHER'S NAME			15 MOTHER'S MAIDEN NAME			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO		
Harry Troup			Mary Jane Troup			no					
17 INFORMANT			18 ADDRESS			19 Son			Mr. Luther Leo Walker, Cumberland, Md.		
18 CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c))											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)											SUDDENLY
DUE TO, OR AS A CONSEQUENCE OF											
CORONARY OCCLUSION											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.											--
(b)											
DUE TO, OR AS A CONSEQUENCE OF											
CORONARY SCLEROSIS											
(c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>			21b. TIME OF INJURY Month, Day, Year			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
CAUSE OF DEATH			P.M. 19								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No			City or Town County State		
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <i>Benedict Skitarelic</i>						CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED		
EXAMINER'S NAME (Type) Dr. Benedict Skitarelic, M.D.						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			April 8, 1968		
						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			Rt. 9 Cumberland		
ADDRESS (Street, city, town, or county)											
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)		
Burial			Apr. 11, 1968			Davis Memorial Cemetery			Cumberland, Allegany, Md.		
24 FUNERAL DIRECTOR						25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE		
James F. Scarpeali, Cumberland, Md.						APR 16 1968			<i>Charles Judge</i>		



# FOR STATE HEALTH DEPT

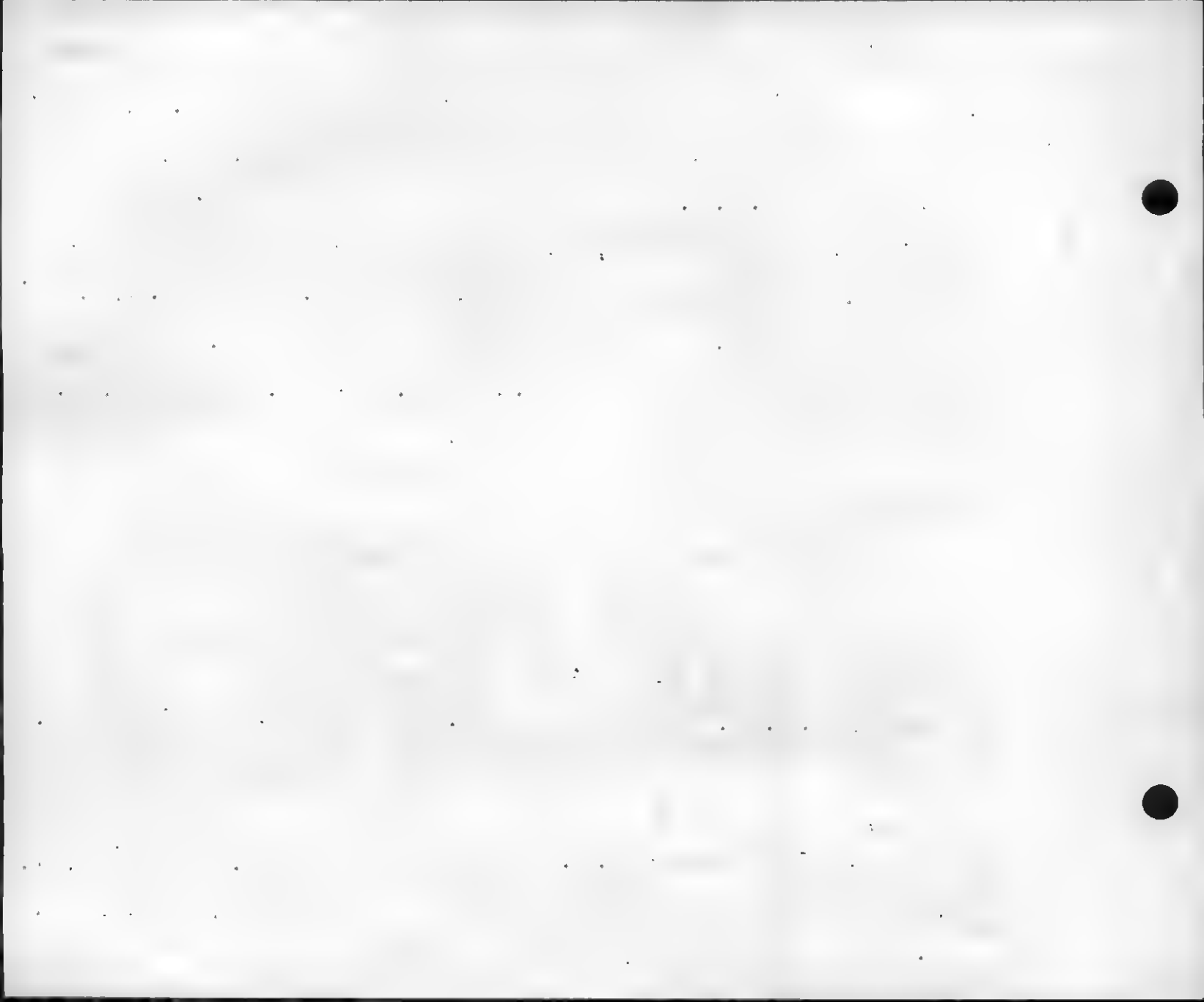
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## DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

### MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 DECEASED-NAME (Type or Print)		First	Middle	Last	2a DATE KNOWN OF ESTI- DEATH MATED		Month	Day	Year	2b HOUR		
Mary		Ann	Walker	2c DATE PRONOUNCED DEAD		Month	Day	Year	2d HOUR			
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (in years last birthday)	7 UNDER 1 YEAR MONTHS	8 UNDER 24 HRS DAYS	9 UNDER 24 HRS HOURS	10 MIN	2c DATE PRONOUNCED DEAD		2d HOUR		
Female	White	July 11, 1957	10 YRS					Month	Day	Year		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH						
Maryland		U. S. A.				Allegany		Md.				
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY						
Cumberland		D.O.A., Sacred Heart		Student		Grade School						
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET AND NUMBER				
Id.		Allegany		Cumberland				Rt. # 6 Along U.S. RT. 220		Sg.		
14 FATHER'S NAME		First	Middle	Last	15 MOTHER'S MAIDEN NAME		First	Middle	Last			
Edward		B.	Walker		Beatrice		V.	Shelley				
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b SOCIAL SECURITY NO (If yes give war or dates of service)		17 INFORMANT		ADDRESS						
No		None		Mr. Edward B. Walker		Rt. 6 Cumberland, Id.						
18 CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)										Sudden		
DU TO, OR AS A CONSEQUENCE OF												
(b)												
DU TO, OR AS A CONSEQUENCE OF												
(c)												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)												
19a DATE OF OPERATION											19b CONDITION FOR WHICH OPERATION WAS PERFORMED?	20 AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>		21b TIME OF INJURY Month, Day, Year		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18)								
CAUSE OF DEATH		8 4/28 19 68		Struck by automobile								
21d INJURY OCCURRED		21e PLACE OF INJURY (At home, farm, street, factory, office, building, etc.)		21f LOCATION Street or R.F.D. No		City or Town		County		State		
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		U.S. RT. 220 North of		Rt. # 6		Rallings		Allegany		Id.		
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspect on <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>												
ACTUAL SIGNATURE		Benedict Skitarelic		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		22b DATE SIGNED		
EXAMINER'S NAME (Type)		BENEDICT SKITARELIC, M. D.		DEPUTY MED. CAL. EXAMINER <input checked="" type="checkbox"/>		ADDRESS (Street, city, town, or county)		Rt. 9 Cumberland, Id.		April 28, 1968		
23a BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town)		(County)		(State)		
Burial		5/1/68		Hillcrest Burial Park		Cumberland		Allegany		Id.		
24 FUNERAL DIRECTOR		ADDRESS		25a REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE						
H. Wayne George		Cumberland, Maryland		MAY 01 1968		Charles Judge						



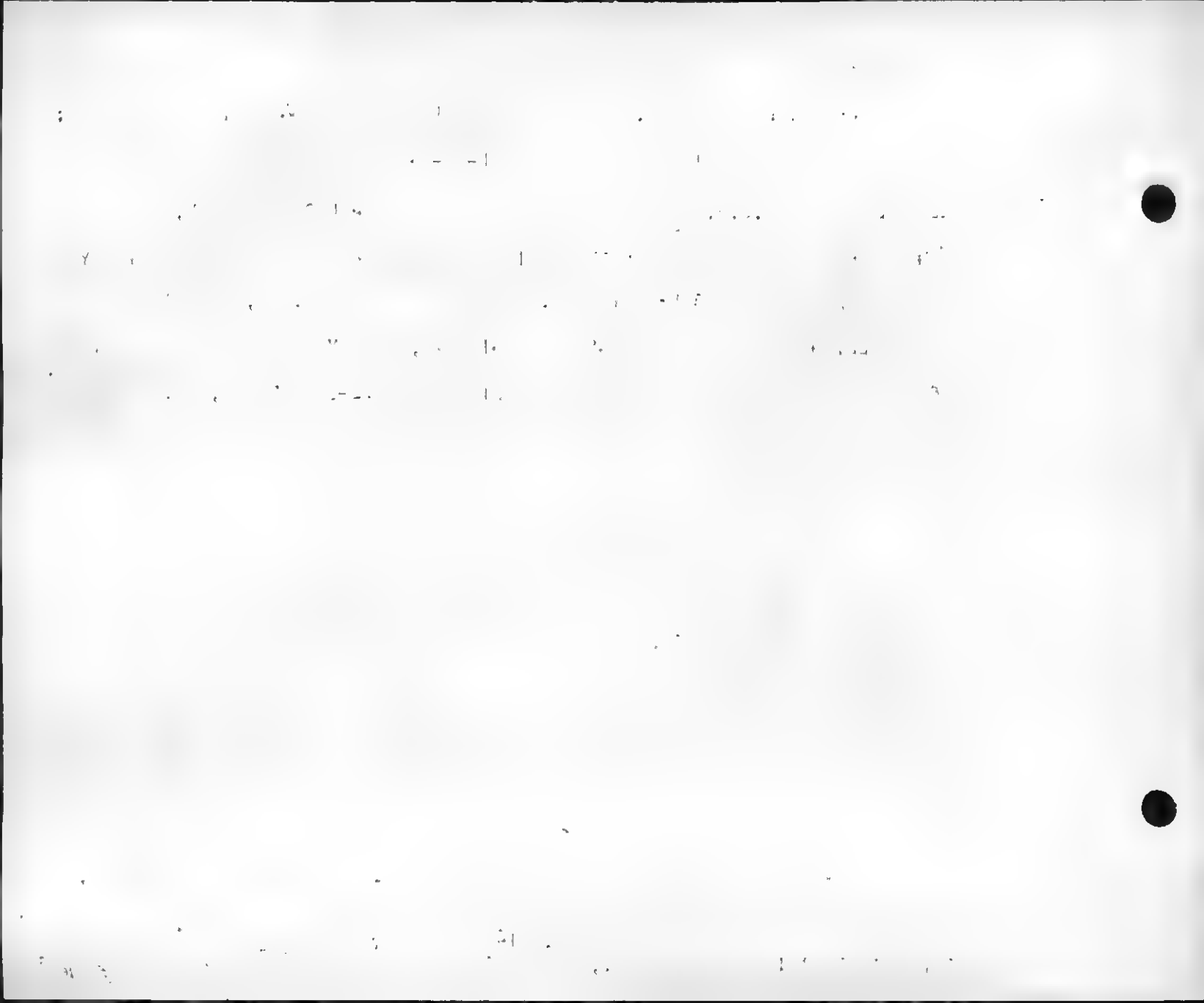


TO HOSPITAL OR ATTENDING PHYSICIAN: The form requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers and page 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1  
5030  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

1 DECEASED-NAME (Type or print) First Middle Last FREDERICK W. WATKINS			2a DATE OF DEATH Month Day Year 04 18 68		2b HOUR 5:55 M
3 SEX MALE	4 RACE WHITE	5 DATE OF BIRTH 01-20-08		6 AGE (In years last birthday) 60 YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN
7a BIRTHPLACE (State or foreign country) ALABAMA	7b CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH ALLEGANY COUNTY, Md		
10 CITY OR TOWN OF DEATH CUMBERLAND	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) SACRED HEART HOSPITAL		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) FIREMAN		12b KIND OF BUSINESS OR INDUSTRY BRICK YARD
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE MARYLAND	13b COUNTY ALLEGANY	13c CITY OR TOWN MT. SAVAGE	13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e STREET AND NUMBER RT. #1, BOX 21	
14 FATHER'S NAME First Middle Last WILLIAM WATKINS		15 MOTHER'S MAIDEN NAME First Middle Last BIELETZ, MARY WATKINS			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, No (If yes give war or dates of service) No		16b SOCIAL SECURITY NO. 212-1-9130	17 INFORMANT Address HOSPITAL RECORDS-CUMBERLAND, MD. 21502		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 months
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) <u>Intestinal obstruction</u>					
19a DATE OF OPERATION 26 Mar 68	19b CONDITION FOR WHICH OPERATION WAS PERFORMED Biopsy Basilla		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner) White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21b TIME OF INJURY Hour AM Month Day Year P.M. 19	21c HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18)			
21d INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f LOCATION Street or R.F.D. No	City or Town	County	State
22a I certify that (I) (this hospital) attended the deceased from 17 Apr, 1968, to 17 Apr, 1968, that (I) (we) last saw the deceased alive on 17 Apr, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b SIGNATURE Dr. F. W. Miltenberger			22c DATE SIGNED 4/18/68	22d PHYSICIAN'S NAME (Type) DR. F. W. MILTENBERGER	
22e ADDRESS 122 S. CENTRE ST., CUMBERLAND, MD.			22f DATE SIGNED APR 22 1968		
23a BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b DATE APR. 20 '68	23c NAME OF CEMETERY OR CREMATORY SUNSET MEMORIAL PARK	23d LOCATION (City or Town) CUMBERLAND, MD.	23e LOCATION (County) (State) (County) (State)	
24 FUNERAL DIRECTOR DURST FUNERAL HOME-57 FROST AVE., FROSTBURG,			25a REGD. BY REGISTRAR DATE APR 22 1968		

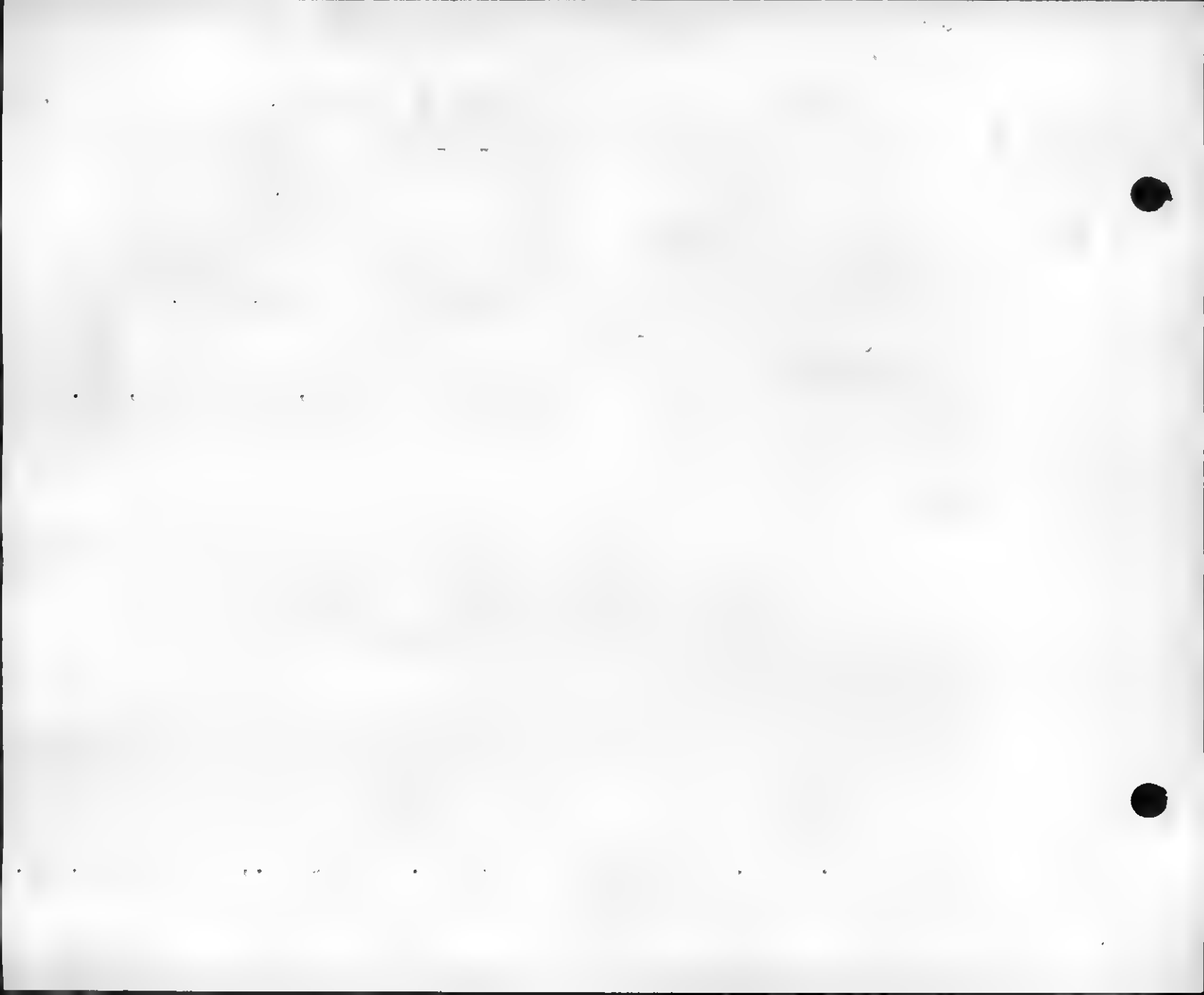


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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) <b>CORA</b>			First Middle Last <b>M WHISNER</b>			2a. DATE OF DEATH Month Day Year <b>APRIL 10 1968</b>			2b. HOUR AM PM <b>4:25</b>		
3 SEX <b>FEMALE</b>			4. RACE <b>WHITE</b>			5. DATE OF BIRTH <b>3-26-1892</b>			6 AGE (In years last birthday) <b>76</b> YRS		
7a BIRTHPLACE (State or foreign country) <b>Maryland</b>			7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 COUNTY OF DEATH <b>ALLEGANY</b> Md.		
10 CITY OR TOWN OF DEATH <b>CUMBERLAND</b>			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital) <b>MEMORIAL HOSPITAL</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY		
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <b>MARYLAND</b>			13b COUNTY <b>ALLEGANY</b>			13c CITY OR TOWN <b>CUMBERLAND</b>			13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
13e STREET AND NUMBER <b>1310 LEXINGTON AVENUE</b>			14. FATHER'S NAME First Middle Last <b>JOHN GORDON</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>DELLA BELTZ</b>					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or Unknown) (If yes give year or dates of service)			16b SOCIAL SECURITY NO			17 INFORMANT <b>MEMORIAL HOSPITAL, CUMBERLAND, MD.</b>			Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hypertensive C.V. Dis.</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>many years.</b> DUE TO, OR AS A CONSEQUENCE OF (c) PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Diabetes Mellitus, severe.</b>											
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. F YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e PLACE OF INJURY (AT HOME FARM STREET, FACTORY, OFFICE BUILDING ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <b>5-9-1951</b> , to <b>4-10-1968</b> , that (I) <del>(was)</del> last saw the deceased alive on <b>4-9-1968</b> and that in (my) <del>(our)</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>(we)</del> <del>(did)</del> view the body after death.											
22b SIGNATURE <b>Wm. F. Williams</b>			DEGREE			ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>			22c DATE SIGNED <b>4-10-68</b>		
22d. PHYSICIAN'S NAME (Type) <b>DR. W. F. WILLIAMS</b>			22e. ADDRESS <b>122 S. CENTRE ST., CUMBERLAND, MD.</b>								
23a BURIAL, CREMATION, REMOVAL <b>Burial</b>			23b DATE <b>Apr. 12, 1968</b>			23c NAME OF CEMETERY OR CREMATORY <b>Rest Lawn Mem. Gardens</b>			23d LOCATION (City or Town) (County) (State) <b>Cumberland, Allegany, Md.</b>		
24 FUNERAL DIRECTOR <b>James F. Scarpelli, Cumberland, Md.</b>			ADDRESS			25a. REGISTRAR <b>APR 13 1968</b>			25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

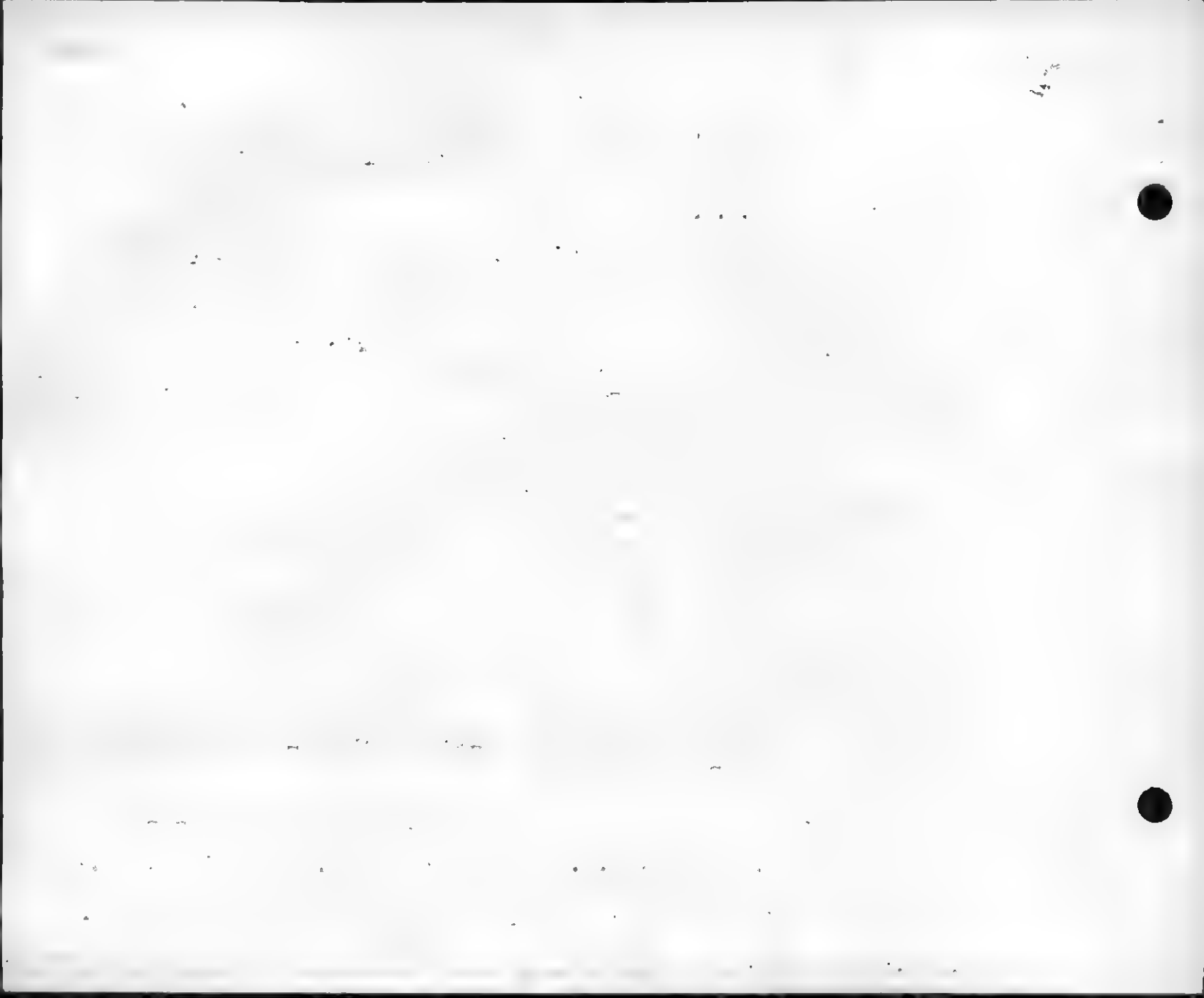
VR A15 (4)  
30M REV 1/68

MD  
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35032

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

1 DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH		2b. HOUR	
Andrew				Wilson	Month Day Year April 30 1968		3:30 AM	
3 SEX	4 RACE		5 DATE OF BIRTH		6 AGE (In years lost birthday)		7 IF UNDER YEAR MONTHS DAYS	
Male	White		March 8, 1891		77 YRS			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		
Scotland		U.S.A.				Allegany Md.		
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY		
Cumberland		817 Calvin Street		Retired machinist - Celanese Corp				
13a. USUAL RESIDENCE (Where deceased lived, if institution admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		3e. STREET AND NUMBER
Maryland		Allegany		Cumberland		YES		817 Calvin Street
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME		First	Middle Last
William Wilson					Isabella			Teas
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		(If yes give war or dates of service)		16b. SOCIAL SECURITY NO		17 INFORMANT		
No				214-07-6370		Kenneth Wilson		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		PART I DEATH WAS CAUSED BY		IMMEDIATE CAUSE (a)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
4109				Coronary Occlusion		1 days		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b)		Coronary Heart Disease		10 years		
		(c)						
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)								
MEDICAL CERTIFICATION								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION		Street or R.F.D. No City or Town County State		
22a. I certify that (I) (this hospital) attended the deceased from 8-30, 1949, to 4-30, 1968, that (I) (we) last saw the deceased alive on 4-30, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE		Ralph W. Ballin, M.D.		DEGREE		ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 5-1-68
22d. PHYSICIAN'S NAME (Type)		Ralph W. Ballin, M.D.		22e. ADDRESS 62 Greene St. Cumberland, Md. 21502				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)		
Burial		5/3/68		Hillcrest Burial Park		Cumberland Alleg Maryland		
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
H. Lee Silcox		Cumberland Maryland 21502		DATE MAY 6 1968		Charles J. J...		

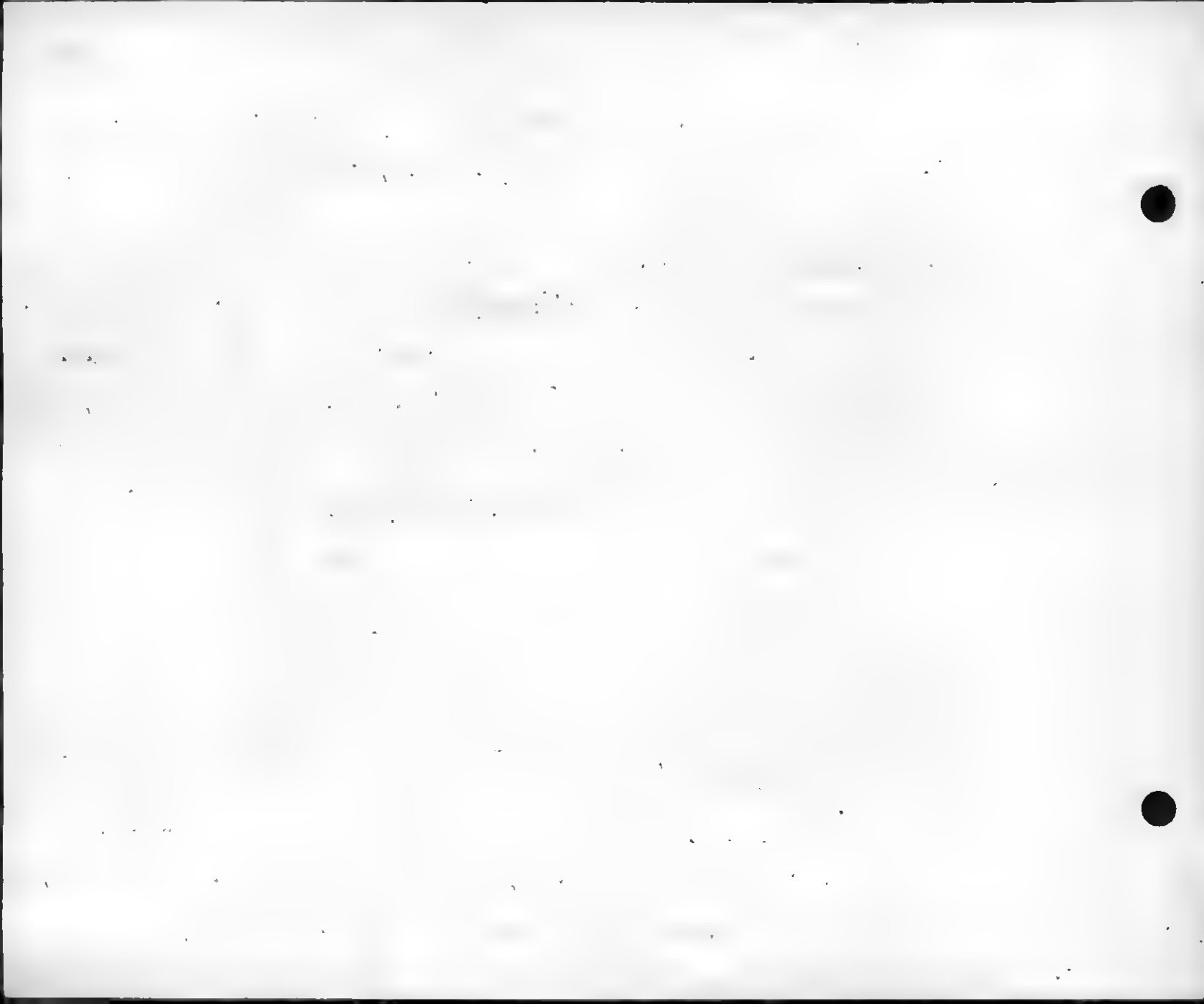


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV 1/68

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1 DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH		2b. HOUR	
DOROTHY B. WILSON						Month Day Year		APRIL 20 1968 6 P <sup>M</sup>	
3 SEX		4. RACE		5 DATE OF BIRTH		6 AGE (In years last birthday)		7 UNDER 1 YEAR	
FEMALE		WHITE		MARCH 15, 1909		59 YRS		MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH			
MARYLAND		USA				ALLEGANY Md.			
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
CUMBERLAND		MEMORIAL HOSPITAL							
13a. USUAL RESIDENCE (Where deceased lived, if admission)		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER	
MARYLAND		ALLEGANY		CORRIGANVILLE		NO <input checked="" type="checkbox"/>			
14 FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
First Middle Last			First Middle Last						
NORMAN W. BRANT			VILETTA PITZER						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.		17 INFORMANT Address				
NO			213 22 3759		THEODORE F. WILSON CORRIGANVILLE MD.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1 DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) Acute Coronary Occlusion									minutes
DUE TO, OR AS A CONSEQUENCE OF									
(b) Atherosclerotic Cardiovascular Disease									Months
DUE TO, OR AS A CONSEQUENCE OF with old posterior Myocardial Infarction									
(c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
T									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)					
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		HOUR A.M. Month Day Year P.M. 19							
21d. INJURY OCCURRED		21a. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION		City or Town		County State	
While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>									
22a. I certify that (I) (this hospital) attended the deceased from 2-2-68, 19, to April, 19 68, that (I) (we) last saw the deceased alive on April 16, 19 68, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.									
22b. SIGNATURE		DEGREE		ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED			
						4-22-68			
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS							
G. OVERTON HIMMERWRIGHT, M.D.		133 VIRGINIA AVE. CUMBERLAND, MD							
23a. BURIAL, CREMATION REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County) (State)	
BURIAL		APRIL 23, 1968		SUNSET MEMORIAL		CUMBERLAND, MD			
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
BYRON KIGHT		CUMBERLAND, MD.		DATE		APR 24 1968			





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV 1/68

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05036

1 DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH		2b. HOUR		
EDITH		B.		WILSON	04 Month 30 Day 68 Year		2:30 PM		
3 SEX	4 RACE		5 DATE OF BIRTH		6 AGE (in years month birthday)		IF UNDER 1 YEAR MONTHS DAYS		
FEMALE	WHITE		12-25-92 12-23-1892		75 YRS				
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		Md.		
SCOTLAND	USA				ALLEGANY				
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		12a. USUAL OCCUPATION (Kind of work done during most of life, if retired)		12b. KIND OF BUSINESS OR INDUSTRY			
CUMBERLAND		SACRED HEART HOSPITAL		HOUSEWIFE		Home			
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
MARYLAND		ALLEGANY		CUMBERLAND				817 CALVIN STREET	
14. FATHER'S NAME First Middle Last			15 MOTHER'S MAIDEN NAME First Middle Last						
ALEXANDER			CHALMERS			Lizzie Bremner			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)		16b. SOCIAL SECURITY NO		17 INFORMANT		Address			
NO		211-07-6370B		SACRED HEART HOSPITAL		900 SETON DRIVE CUMBERLAND, MD. 21502			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DISSECTING AORTIC ANEURYSM								1 DAY	
4410									
DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
DUE TO, OR AS A CONSEQUENCE OF									
(b)									
(c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
451X CORONARY HEART DISEASE									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from 9-15, 1954, to 4-30, 1968, that (I) (we) last saw the deceased alive on 4-30, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE		22c. DATE SIGNED		22d. PHYSICIAN'S NAME (Type)					
L. G. Ballin, M.D.		5-1-68		DR. BALLIN					
22e. ADDRESS		22f. ADDRESS							
62 GREENE ST., CUMBERLAND, MD. 21502									
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		May 3, 1968		Hillcrest Burial Park		Cumberland Allegany Md.			
24 FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
H. Lee Silcox		404 Decatur St. Cumb. Md.		MAY 6 1968		Charles Judge			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (ages 16 and 17) and should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH													
1 DECEASED-NAME (Type or print)			First		Middle		Last		2a DATE OF DEATH Month Day Year		2b. HOUR		
GEORGE			HENRY		WINTERS				04 24 68		7:25 AM		
3. SEX			4 RACE			5 DATE OF BIRTH			6. AGE (n years lost birthday)		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		
MALE			WHITE			07 18 85			82 YRS				
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH				
MARYLAND			USA						ALLEGANY			Md	
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY				
CUMBERLAND			SACRED HEART HOSPITAL			Ret. Foreman			Rwy. Express				
13a. USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIM TSP YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER	
MD.			ALLEGANY			CUMBERLAND			YES			701 GEPHART DRIVE	
14 FATHER'S NAME			15. MOTHER'S MAIDEN NAME										
First Middle Last			First Middle Last										
GEORGE W. WINTERS			GERTRUDE LONG										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO			17 INFORMANT			900 SEPTON DRIVE				
NO			714 10 2501			SACRED HEART HOSPITAL			CUMBERLAND, MD.				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cause of the lung</u> 162.1 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 year			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 162.1													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)			21f. LOCATION Street or RFD No City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from 3-2-1967, to 4-24-1968, that (I) (we) last saw the deceased alive on 4-23-1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <u>E. Brings</u>			DEGREE			ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED 4-25-64				
22d. PHYSICIAN'S NAME (Type)			22e. ADDRESS										
BLANE M. SCHINDLER			57 Lewis Brings			09 GREENE STREET CUMBERLAND, MARYLAND 21502							
23a. BURIAL, CREMATON, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)				
Burial			4/27/68			Sunset Memorial Park			Cumberland, Allegany Md.				
24. FUNERAL DIRECTOR			ADDRESS			25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE				
H. Wayne George			Cumberland, Md.			DATE APR 29 1968			H. Wayne George				



# FOR STATE HEALTH DEPT.

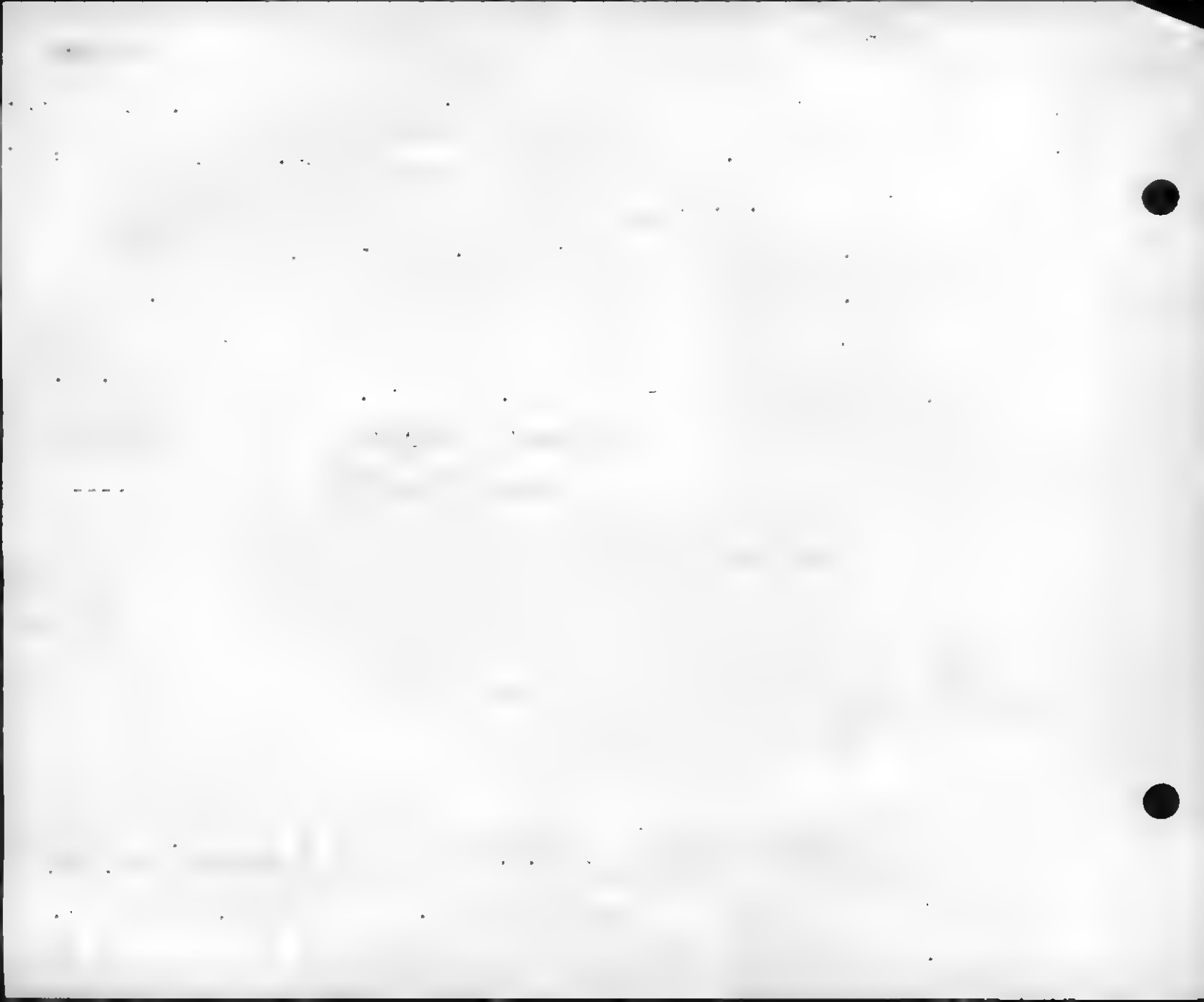
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PH-100-1. 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

05036

## DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15034

1 DECEASED NAME (Type or Print) <i>Nellie Virginia Wolford</i>			2a DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month Day Year <i>Apr. 27, 1968</i>			2b HOUR <i>7:00 P.M.</i>		
3 SEX <i>Female</i>	4 RACE <i>White</i>	5 DATE OF BIRTH <i>Sept. 28, 1899</i>	6 AGE (in years last birthday) <i>68 YRS</i>	7 UNDER 1 YEAR MONTHS DAYS HOURS MIN	2c DATE PRONOUNCED DEAD Month Day Year <i>Apr. 27, 1968</i>			2d HD JR <i>B</i>
7a BIRTHPLACE (State or foreign country) <i>Maryland</i>		7b CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH <i>Allegany</i> Md		
10 CITY OR TOWN OF DEATH <i>Cumberland</i>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>415 Pulaski St.</i>			12a USUA. OCCUPATION (Kind of work done during most of working life, even if retired) <i>Domestic</i>		12b KIND OF BUSINESS OR INDUSTRY <i>Domestic</i>	
13a USUAL RESIDENCE (Where deceased lived, if institution admission) STATE <i>Id.</i>		13b COUNTY <i>Allegany</i>		13c CITY OR TOWN <i>Cumberland</i>		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER <i>415 Pulaski St.</i>
14 FATHER'S NAME First Middle Last <i>George -- Dean</i>			15 MOTHER'S MAIDEN NAME First Middle Last <i>Sallie -- Swigert</i>			16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes no, or unknown) <i>No</i>		
16b SOCIAL SECURITY NO. <i>215-76-9702</i>			17 INFORMANT <i>Mrs. Virginia L. Ba'kner</i>			ADDRESS <i>Cum. Hl. 730 Columbia Ave.</i>		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>CORONARY OCCLUSION</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>CORONARY SCLEROSIS</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>----</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>SUDDEN</b>
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>None</i>								
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b TIME OF INJURY Month, Day, Year HOUR A.M. P.M. <i>19</i>			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18)		
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f LOCATION Street or R.F.D. No City or Town County State		
22a I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE <i>Benedict Skitarelic</i>			EXAMINER'S NAME (Type) <b>BENEDICT SKITARELIC, M.D.</b>			22b DATE SIGNED <i>Apr. 27, 1968</i>		
23a BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>			23b DATE <i>4/30/68</i>			23c NAME OF CEMETERY OR CREMATORY <i>Trinity Lutheran Cem.</i>		
24 FUNERAL DIRECTOR <i>H. Gayne George</i>			ADDRESS <i>Cumberland, Maryland</i>			25a REC'D BY REGISTRAR DATE <b>MAY 01 1968</b>		
						25b REGISTRAR'S SIGNATURE <i>Charles Judge</i>		
23d LOCATION (City or Town) <i>Cumberland</i>			23e COUNTY <i>Allegany</i>			23f STATE <i>Md.</i>		

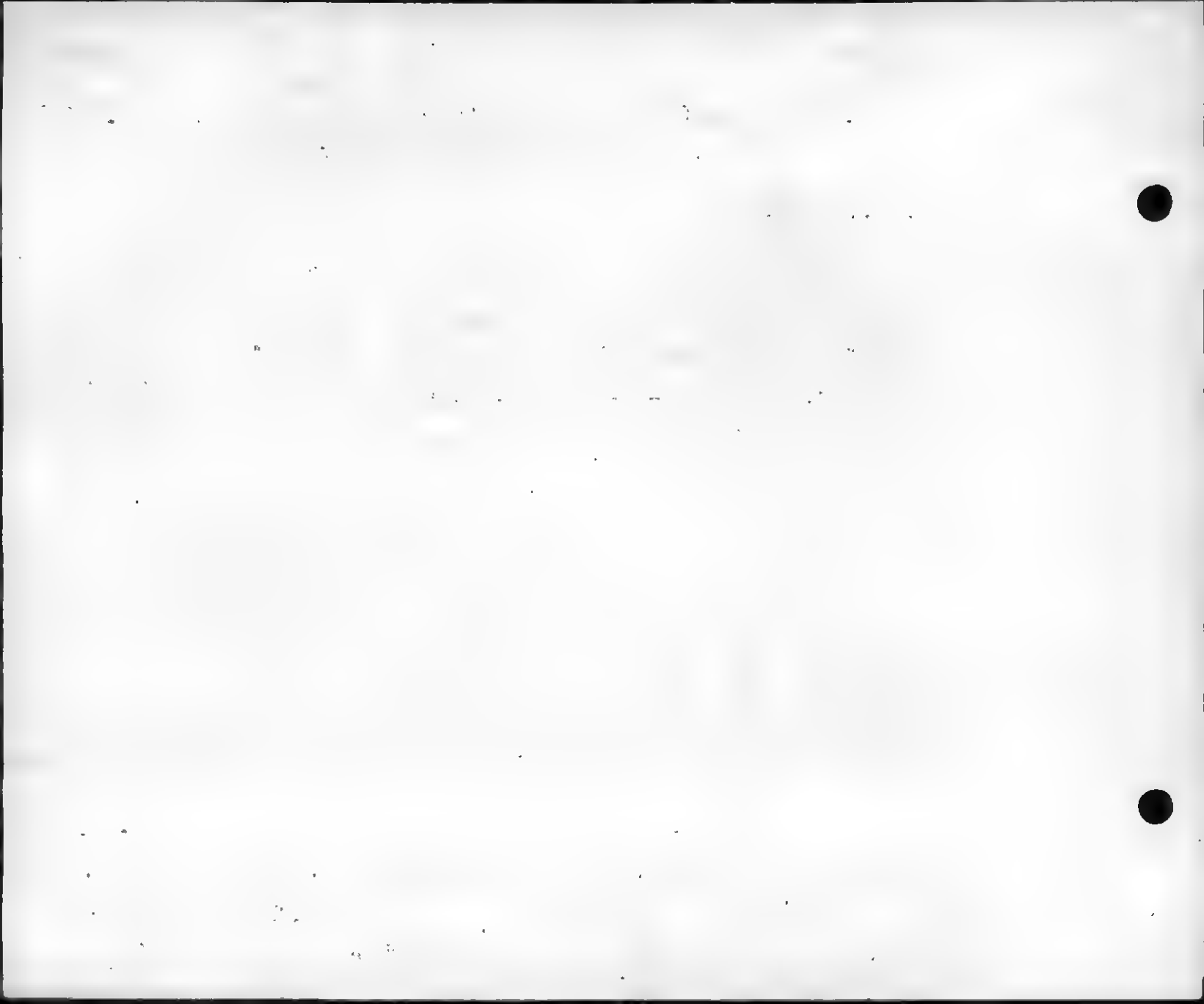


**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**  
**CERTIFICATE OF DEATH**

1 DECEASED NAME (Type or print) <b>Dis</b> <b>GEORGE</b> <b>Wolford</b>		2a DATE OF DEATH Month <b>4</b> Day <b>12</b> Year <b>1968</b>		2b HOUR <b>5:45 A M</b>
3 SEX <b>M</b>	4 RACE <b>W</b>	5. DATE OF BIRTH <b>2-17-1894</b>	6 AGE (In years last birthday) <b>74</b> YRS.	IF UNDER 1 YEAR MONTHS <b>7</b> DAYS <b>7</b>
7a BIRTHPLACE (State or foreign country) <b>HOYE, W.VA.</b>	7b CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9 COUNTY OF DEATH <b>Allegany</b> Md	
10 CITY OR TOWN OF DEATH <b>Cumberland, Md.</b>	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Cumberland Nursing Center</b>	12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>ACETATE DEPT.</b>	12b KIND OF BUSINESS OR INDUSTRY <b>CELANESE</b>	
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <b>Maryland</b>	13b COUNTY <b>Allegany</b>	13c CITY OR TOWN <b>Frostburg, Md.</b>	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e STREET AND NUMBER <b>24 Depot St.</b>
14 FATHER'S NAME First <b>IRVIN</b> Middle <b>GEORGE</b> Last <b>WOLFORD</b>		15 MOTHER'S MAIDEN NAME First <b>UNKNOWN</b> Middle <b>UNKNOWN</b> Last <b>UNKNOWN</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>NO</b> (If yes give year or dates of service) <b>N.A.</b>		16b SOCIAL SECURITY NO <b>214-07-1633</b>		17 INFORMANT <b>MR. LEROY WOLFORD, FROSTBURG, MD., 24 DEPOT ROAD.</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary artery disease</b> <b>1st</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>arteriosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>1 year</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>1 year</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>6 months</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)				
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from <b>3-8-1968</b> , to <b>4-12-1968</b> , that (I) (we) last saw the deceased alive on <b>4-10-1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.				
22b. SIGNATURE <b>L. Brings</b>		DEGREE <b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED <b>4-12-68</b>	
22d. PHYSICIAN'S NAME (Type) <b>LEWIS BRINGS, M.D.</b>		22e. ADDRESS <b>57 GREENE ST., CUMBERLAND, MD.</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE <b>4/15/68</b>	23c. NAME OF CEMETERY OR CREMATORY <b>FROSTBURG MEM. PARK</b>	23d. LOCATION (City or Town) (County) (State) <b>FROSTBURG ALLEGANY, MD.</b>	
24. FUNERAL DIRECTOR <b>MARIELOU M. SOWERS, HAFFER-SOWERS FUNERAL HOME, 60 W. MAIN, FROSTBURG</b>		25a. REC'D BY REGISTRAR <b>APR 16 1968</b>	25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>	

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that this death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.





**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

X

MEDICAL CERTIFICATION

**ACTUAL  
SIGNATURE**

EXAMINER'S  
NAME (Type)

Benedict Skitarelic, M.D.

23a. BURIAL, CREMATION,  
REMOVAL (Specify)  
**BURIAL**

23b. DATE

APR. 20 '68

23c. NAME OF CEMETERY OR CREMATORY

ST. PATRICK'S CEMETERY

23d. LOCATION (City or Town)

MT. SAVAGE, MD.

22b. DATE SIGNED

APR. 18, 1968

Cumberland, Md.

250. REC'D BY REGISTRAR

DATE APR 22 1968

25b. REGISTRAR'S SIGNATURE

368 Charles Judge

**MARYLAND STATE DEPARTMENT OF HEALTH**

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or Print)		First		Middle		Last		2a. DATE KNOWN OF DEATH		Month		Day		Year		2b. HOUR	
MARY		YANTZ						2a. DATE KNOWN OF DEATH		4		17		168		9:30	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years just birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS		2c. DATE PRONOUNCED DEAD		2d. HOUR			
FEMALE		WHITE		NOV. 8, 1888		79 YRS.		MONTHS		DAYS		HOURS		MIN.			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		9. COUNTY OF DEATH									
MARYLAND		U.S.A.		WIDOWED		DIVORCED		ALLEGANY									
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY											
FROSTBURG		196 1/2 GLENN STREET		HOUSE WORK		OWN HOME											
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER									
MARYLAND		ALLEGANY		FROSTBURG		YES		196 1/2 GLENN STREET									
14. FATHER'S NAME		First		Middle		Last		15. MOTHER'S MAIDEN NAME		First		Middle		Last			
JAMES		HENAGHAN		MINNIE		MEARS											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS		196 1/2 GLENN ST.,		21532							
(Yes, no, or unknown)		NONE		MRS. ALMA RUPP, FROSTBURG, MD.													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))																APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY:																Sudden	
IMMEDIATE CAUSE (a) Coronary Occlusion																	
DUE TO, OR AS A CONSEQUENCE OF																	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.																	
(b) Coronary Sclerosis																	
DUE TO, OR AS A CONSEQUENCE OF																	
(c)																	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																	
4201																	
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY?					
												YES					
21a. EXTERNAL CAUSE WAS PRIMARY				21b. TIME OF INJURY Month, Day, Year				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)									
OR CONTRIBUTING				HOUR A.M.													
CAUSE OF DEATH				P.M.													
21d. INJURY OCCURRED				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No.				City or Town					
WHILE AT WORK												County					
NOT WHILE AT WORK												State					
22a. I certify that I took charge of the remains described above, held an Autopsy, Inspection, Inquiry, and in my opinion death resulted from: Natural causes, Accident, Suicide, Homicide, Undetermined manner																	
Benedict Skitarelic, M.D.																	
CHIEF MEDICAL EXAMINER																	
ASSISTANT MEDICAL EXAMINER																	
DEPUTY MEDICAL EXAMINER																	
ADDRESS (Street, city, town, or county)																	
Cumberland, Md.																	
22b. DATE SIGNED																	
APR. 18, 1968																	
23a. BURIAL CREMATION, REMOVAL (Specify)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION (City or Town) (County) (State)					
BURIAL				APR. 20 '68				ST. PATRICK'S CEMETERY				MT. SAVAGE, MD.					
24. FUNERAL DIRECTOR										25a. REC'D BY REGISTRAR				25b. REGISTRAR'S SIGNATURE			
JOSEPH R. DURST, FROSTBURG, MD. 21532										DATE				APR 23 1968			
										Charles Jones							

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<div style="display: flex; justify-content: space-between;"> <span>05039</span> <span>DIVISION OF VITAL RECORDS - 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</span> <span>05041</span> </div>											
<div style="display: flex; justify-content: space-between;"> <span>Item 23 Film 0400 5/2/68 kk</span> <span>CERTIFICATE OF DEATH</span> </div>											
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR A		
FRANK			J. YOCKUS			04 Month 24 Day Year 68			1:40 M		
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (In years last birthday)		
MALE			WHITE			02-18-13			55 YRS.		
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH		
WEST VIRGINIA			U.S.A.						ALLEGANY COUNTY, Md.		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
CUMBERLAND			SACRED HEART HOSPITAL			LABORER			CELANESE CORP		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN R.D.			13d. STREET AND NUMBER		
MARYLAND			ALLEGANY			CUMBERLAND			RT. #3, BOX 614, NAVES CROSS		
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last								
ANTHONY YOCKUS			O'KNICK, MARY YOCKUS								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO.			17. INFORMANT			Address		
YES			232-03-1388			SACRED HEART HOSPITAL RECORDS-900 SETON DR.			CUMB., MD. 21502		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART 1. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) <u>Respiratory arrest</u>											
DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
(b) <u>Cerebrovascular Accident</u>											
DUE TO, OR AS A CONSEQUENCE OF											
(c) <u>Arteriosclerosis</u>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
<u>331X Generalized arteriosclerosis</u>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Clarence J. Vincent M.D.</u> DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>									22c. DATE SIGNED		
22d. PHYSICIAN'S NAME (Type) DR. C. VINCENT - BMG									22e. ADDRESS 126 N. SMALLWOOD ST., CUMB., MD. 21502		
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)		
Burial			4/26/68			Sts. Peter & Paul Cemetery			Cumberland Allegany Md.		
24. FUNERAL DIRECTOR <u>Stein's Funeral Home</u> ADDRESS MD. 21502						25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE		
STEIN'S FUNERAL HOME-117 FREDERICK ST., CUMB.						APR 26 1968			<u>Clarence J. Vincent</u>		

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